DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

[CMS–1504–FC and CMS–1498–IFC2]

RIN 0938–AP82 and RIN 0938–AP80

Medicare Program: Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Payments to Hospitals for Graduate Medical Education Costs; Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations; Payment for Certified Registered Nurse Anesthetist Services Furnished in Rural Hospitals and Critical Access Hospitals

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

ACTION: Final rule with comment period; final rules; and interim final rule with comment period.

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

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

In this document, we also are including two final rules that implement provisions of the Affordable Care Act relating to payments to hospitals for direct graduate medical education (GME) and indirect medical education (IME) costs; and new limitations on certain physician referrals to hospitals in which they have an ownership or investment interest.

In the interim final rule with comment period that is included in this document, we are changing the effective date for otherwise eligible hospitals and critical access hospitals that have been reclassified from urban to rural under section 1886(d)(8)(E) of the Social Security Act and 42 CFR 412.103 to receive reasonable cost payments for anesthesia services and related care furnished by nonphysician anesthetists from cost reporting periods beginning on or after October 1, 2010, to December 2, 2010.

DATES: *Effective Dates:* The provisions of these rules are effective January 1, 2011, except for the amendment to 42 CFR 412.113(c)(2)(i)(A), which is effective on December 2, 2010.

Applicability Dates: (1) The amendments to 42 CFR 412.105(f)(1)(ii)(A), (B), (C), and (D) are applicable retroactive to January 1, 1983; (2) the amendment to 42 CFR 412.105(f)(1)(ii)(E) is applicable retroactive to July 1, 2010; (3) the amendments to 42 CFR 412.105(f)(1)(iii)(C) and (D) are applicable retroactive to January 1, 1983; (4) the amendment to 42 CFR 413.75(b) is applicable retroactive to July 1, 2009; (5) the amendment to 42 CFR 413.78(f)(1) is applicable retroactive to July 1, 2009; (6) the amendment to 42 CFR 413.78(g) is applicable retroactive to July 1, 2010; and (7) the amendment to 42 CFR 413.78(h) is applicable retroactive to January 1, 1983. In accordance with sections 1871(e)(1)(A)(i) and (e)(1)(A)(ii) of the Social Security Act, the Secretary has determined that the retroactive application of the specified regulatory amendments is necessary to comply with the statute and that failure to apply these changes retroactively would be contrary to public interest.

Comment Period: To be assured consideration, comments on the payment classifications assigned to HCPCS codes identified in Addenda B, AA, and BB to the final rule with comment period with the "NI" comment indicator and on other areas specified throughout the final rule with comment period, must be received at one of the addresses provided in the **ADDRESSES** section no later than 5 p.m. EST on January 3, 2011.

To be assured consideration, comments on the interim final rule with comment period (under section XXIII. of the preamble and the amendment to 42 CFR 412.113(c)(2)(i)(A)) relating to reasonable cost payments to otherwise eligible hospitals and critical access hospitals that have reclassified from urban to rural for anesthesia services and related care furnished by nonphysician anesthetists must be received at one of the addresses provided in the **ADDRESSES** section no later than 5 p.m. EST on January 3, 2011.

Application Deadline—New Class of New Technology Intraocular Lenses: Requests for review of applications for a new class of new technology intraocular lenses must be received by 5 p.m. EST on March 5, 2011.

ADDRESSES: In commenting, please refer to file code CMS–1504–FC for the provisions of the OPPS/ASC final rule with comment period, and to CMS–1498–IFC2 for the interim final rule with comment period. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1504–FC or CMS–1498–IFC2, as applicable, P.O. Box 8013, Baltimore, MD 21244–1850.

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

3. *By express or overnight mail.* You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1504–FC or CMS–1498–IFC2, as applicable, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and

Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

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

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

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

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

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

FOR FURTHER INFORMATION CONTACT: Gift Tee, (410) 786–9316, Hospital outpatient prospective payment issues.

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

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

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

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

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

Marc Hartstein, (410) 786–4539, Pass-through payments for certified registered nurse anesthetists services furnished in rural hospitals and critical access hospitals.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments.

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

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Alphabetical List of Acronyms Appearing in This Federal Register Document

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
AMP Average manufacturer price
AOA American Osteopathic Association
APC Ambulatory payment classification
ASC Ambulatory Surgical Center
ASP Average sales price
AWP Average wholesale price
AWV Annual Wellness Visit
BBA Balanced Budget Act of 1997, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106–113
BCA Blue Cross Association
BCBSA Blue Cross and Blue Shield Association
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106–554
CAH Critical access hospital
CAP Competitive Acquisition Program
CBSA Core-Based Statistical Area
CCR Cost-to-charge ratio
CERT Comprehensive Error Rate Testing
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services
CoP Conditions of Participation
CORF Comprehensive outpatient rehabilitation facility
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2009, copyrighted by the American Medical Association
CRNA Certified registered nurse anesthetist
CY Calendar year
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DMERC Durable medical equipment regional carrier
DRA Deficit Reduction Act of 2005, Public Law 109–171
DSH Disproportionate share hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
EPO Erythropoietin
ESRD End-stage renal disease
FACA Federal Advisory Committee Act, Public Law 92–463
FAR Federal Acquisition Regulations
FDA Food and Drug Administration
FFS Fee-for-service
FSS Federal Supply Schedule
FTE Full-time equivalent
FY Federal fiscal year
GAO Government Accountability Office
GME [Direct] Graduate medical education
HCERA Health Care and Education Reconciliation Act of 2010, Public Law 111–152
HCPCS Healthcare Common Procedure Coding System
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act of 1996, Public Law 104–191
HOPD Hospital outpatient department
HOP QDRP Hospital Outpatient Quality Data Reporting Program
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
ICD–10–CM International Classification of Diseases, Tenth Revision, Clinical Modification
ICD–10–PCS International Classification of Diseases, Tenth Revision, Procedure Coding System
IDE Investigational device exemption
IHS Indian Health Service
IME Indirect medical education
I/OCE Integrated Outpatient Code Editor
IOL Intraocular lens
IPPE Initial preventive physical examination
IPPS [Hospital] Inpatient prospective payment system
IVIG Intravenous immune globulin
MAC Medicare Administrative Contractor
MedPAC Medicare Payment Advisory Commission
MDH Medicare-dependent, small rural hospital
MIEA–TRHCA Medicare Improvements and Extension Act under Division B, Title I of the Tax Relief Health Care Act of 2006, Public Law 109–432
MIPPA Medicare Improvements for Patients and Providers Act of 2008, Public Law 110–275

MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Public Law 110–173
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
NCCI National Correct Coding Initiative
NCD National Coverage Determination
NTIOL New technology intraocular lens
OIG [HHS] Office of the Inspector General
OMB Office of Management and Budget
OPD [Hospital] Outpatient department
OPPS [Hospital] Outpatient prospective payment system
PHP Partial hospitalization program
PM Program memorandum
PPACA Patient Protection and Affordable Care Act of 2010, Public Law 111–148
PPI Producer Price Index
PPPS Personalized preventive plan services
PPS Prospective payment system
PR Pulmonary rehabilitation
PRA Paperwork Reduction Act
QAPI Quality Assessment and Performance Improvement
QIO Quality Improvement Organization
RAC Recovery Audit Contractor
RFA Regulatory Flexibility Act
RHQDAPU Reporting Hospital Quality Data for Annual Payment Update [Program]
RHHI Regional home health intermediary
SBA Small Business Administration
SCH Sole community hospital
SDP Single Drug Pricer
SI Status indicator
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97–248
TOPS Transitional outpatient payments
USPDI United States Pharmacopoeia Drug Information
USPSTF United States Preventive Services Task Force
WAC Wholesale acquisition cost

In this document, we address two payment systems under the Medicare program: The hospital outpatient prospective payment system (OPPS) and the revised ambulatory surgical center (ASC) payment system. In addition, we address provisions of the Affordable Care Act, relating to payments to hospitals for direct graduate medical education (GME) and indirect medical education (IME) costs. We also address provisions relating to new limitations on certain physician referrals to hospitals in which they have an ownership or investment interest and making related changes to the provider agreement regulations. The provisions relating to the OPPS are included in sections I. through XIV. and XVI. through XIX. of this final rule with comment period and in Addenda A, B, C (Addendum C is available on the Internet only; we refer readers to section XVIII.A. of this final rule with comment period), D1, D2, E, L, and M to this final rule with comment period. The provisions related to the revised ASC payment system are included in sections XV., XVI. through XIX. of this final rule with comment period and in Addenda AA, BB, DD1, DD2, and EE to this final rule with comment period. (Addendum EE is available on the Internet only; we refer readers to section XVII.B. of this final rule with comment period.) The provisions related to payments to hospitals for direct GME and IME costs are included in the final rule in section XXI. of this document. The provisions relating to the new limitations on certain physician referrals to hospitals in which they have an ownership or investment interest and related changes to the provider agreement regulations are included in the final rule in section XXII. of this document. The provision relating to a change in the effective date for otherwise eligible rural hospitals and critical access hospitals (CAHs) that have reclassified from urban to rural areas to receive reasonable cost payments for anesthesia services and related care furnished by nonphysician anesthetists is included in the interim final rule with comment period in section XXIII. of this document.

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

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

When Title XVIII of the Social Security Act (the Act) was enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the reasonable cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act (BBA) of 1997 (Pub. L. 105–33) added section 1833(t) to the Act authorizing implementation of a PPS for hospital outpatient services. The OPPS was first implemented for services furnished on or after August 1, 2000. Implementing regulations for the OPPS are located at 42 CFR part 419.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113) made major changes in the hospital outpatient prospective payment system (OPPS). The following Acts made additional changes to the OPPS: the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554); the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Pub. L. 108–173); the Deficit Reduction Act (DRA) of 2005 (Pub. L. 109–171), enacted on February 8, 2006; the Medicare Improvements and Extension Act under Division B of Title I of the Tax Relief and Health Care Act (MIEA–TRHCA) of 2006 (Pub. L. 109–432), enacted on December 20, 2006; the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 (Pub. L. 110–173), enacted on December 29, 2007; the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (Pub. L. 110–275), enacted on July 15, 2008; and most recently the Patient Protection and Affordable Care Act (Pub. L. 111–148), enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), enacted on March 30, 2010. We refer readers to section I.D. of this final rule with comment period for a summary of the provisions of Public Law 111–148, as amended by Public Law 111–152, that we are implementing in this final rule with comment period.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned. We use the Healthcare Common Procedure Coding System (HCPCS) codes (which include certain Current Procedural Terminology (CPT) codes) and descriptors to identify and group the services within each APC group. The OPPS includes payment for most hospital outpatient services, except those identified in section I.B. of this final rule with comment period. Section 1833(t)(1)(B)(i) of the Act provides for payment under the OPPS for hospital outpatient services designated by the Secretary (which includes partial hospitalization services furnished by community mental health centers (CMHCs)) and hospital outpatient services that are furnished to inpatients who have exhausted their Part A benefits, or who are otherwise not in a covered Part A stay.

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

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

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

B. Excluded OPPS Services and Hospitals

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

(IPPS). We set forth the services that are excluded from payment under the OPPS in 42 CFR 419.22 of the regulations.

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

C. Prior Rulemaking

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

Since initially implementing the OPPS, we have published final rules in the **Federal Register** annually to implement statutory requirements and changes arising from our continuing experience with this system. These rules can be viewed on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/*. The CY 2010 OPPS/ASC final rule with comment period appears in the November 20, 2009 **Federal Register** (74 FR 60316). In that final rule with comment period, we revised the OPPS to update the payment weights and conversion factor for services payable under the CY 2010 OPPS on the basis of claims data from January 1, 2008, through December 31, 2008, and to implement certain provisions of Public Law 110–173 and Public Law 110–275. In addition, we responded to public comments received on the provisions of the November 18, 2008 final rule with comment period (73 FR 68502) pertaining to the APC assignment of HCPCS codes identified in Addendum B to that rule with the new interim ("NI") comment indicator, and public comments received on the July 20, 2009 OPPS/ASC proposed rule for CY 2010 (74 FR 35232). On December 31, 2009, we issued in the **Federal Register** (74 FR 69502) a notice that corrected technical and typographic errors that appeared in the CY 2010 OPPS/ASC final rule with comment period issued on November 20, 2009. On August 3, 2010, we issued in the **Federal Register** (75 FR 45700) a notice that contained further corrections of technical errors in the CY 2010 OPPS/ASC final rule with comment period issued in the **Federal Register** on November 20, 2009 (74 FR 60316), and in the correction document for that final rule with comment period that was issued in the **Federal Register** on December 31, 2009 (74 FR 69502).

On August 3, 2010, we issued in the **Federal Register** (75 FR 46169) a proposed rule for the CY 2011 OPPS/ASC payment systems to implement statutory requirements and changes arising from our continuing experience with both systems and to implement certain provisions of the Affordable Care Act.

On August 3, 2010, we issued a notice in the **Federal Register** (75 FR 45769) that contained the final wage indices, hospital reclassifications, payment rates, impacts, and addenda for payments made under the OPPS for CY 2010 and the final payment rates and addenda for payments under the ASC payment system for CY 2010, that were revised to address the provisions of the Affordable Care Act that impacted both the CY 2010 OPPS and the ASC payment system.

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

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

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

costs incurred by other hospitals, the Secretary shall provide for an appropriate adjustment under the authority of section 1833(t)(2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011. This provision is addressed in section II.F. of this final rule with comment period.

- Section 3401(i) of the Affordable Care Act amended section 1833(t)(3) of the Act by, among other things, adding new paragraphs (C)(iv)(F) and (G) to reduce the OPD fee schedule increase factor by a productivity adjustment and an additional adjustment for payments to hospital OPDs beginning in various years from CY 2010 through CY 2019 as applicable. These hospital OPD provisions are addressed in section II.B.1. of this final rule with comment period. Section 3401(k) of the Affordable Care Act amended section 1833(i)(2)(D) of the Act by redesignating clause (v) as clause (iv) and adding a new clause (v) to provide for a similar productivity adjustment for payment for ASC services. This ASC provision is addressed in section XV.H.2.b. of this final rule with comment period.
- Section 4103(a) of the Affordable Care Act amended section 1861(s)(2) of the Act by adding a new subsection (FF) to provide Medicare coverage of "personalized prevention plan services," beginning January 1, 2011. Section 4103(b) of the Affordable Care Act amended section 1861 of the Act by adding a new subsection (hhh) to define "personalized prevention plan services" (also cited as the "annual wellness visit"). Section 4103(c) of the Affordable Care Act excludes the annual wellness visit from payment under the OPPS and provides for the elimination of beneficiary coinsurance requirements for certain preventive services in outpatient hospital settings and for waiver of application of the deductible for these services. These provisions are addressed in section XII.B. of this final rule with comment period.
- Section 4104(a) of the Affordable Care Act amended section 1861(ddd) of the Act to define "preventive services" under Medicare to include screening and preventive services described under subsection (ww)(2) of the Act (other than services under subparagraph (M)); an initial preventive physical examination as defined in subsection (ww) of the Act; and personalized prevention plan services as defined in subsection (hhh)(1) of the Act. Sections 4104(b) and 10406 of the Affordable Care Act amended section 1833(a)(1) of the Act, as amended by section 4103(c)(1) of the Affordable Care Act, to provide for the elimination of coinsurance for preventive services, and section 4104(c) amended section 1833(b) of the Act to provide for the waiver of the application of the deductible for both preventive services and, specifically, for colorectal cancer screening tests that become diagnostic and any related services performed with that diagnostic colorectal cancer screening test performed in the same clinical encounter, effective for items and services furnished on or after January 1, 2011. These provisions are addressed in section XII.B. of this final rule with comment period.
- Sections 5503, 5504, 5505, and 5506 of the Affordable Care Act made a number of changes to various sections of the Act relating to payment for direct GME and IME costs to hospitals.

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

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

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

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

These provisions are addressed in section XXI. of this document.

- Section 6001 of the Affordable Care Act amended section 1877 of the Act to add provisions under new subsection (i) relating to the prohibition against referrals to a hospital by a physician who has an ownership or investment interest in the hospital. This provision is addressed in section XXII. of this document.
- Section 10324(b) of the Affordable Care Act amended section 1833(t) of the Act by adding a new subsection (19) to provide for a floor on the area wage adjustment factor for hospital outpatient department services furnished on or after January 1, 2011, in a State in which at least 50 percent of the counties in the State are frontier counties, that is, a county in which the population per square mile is less than 6. This provision is addressed in section II.C. of this document.

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

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

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of Public Law 106–113, and redesignated by section 202(a)(2) of Public Law 106–113, requires that we consult with an outside panel of experts to review the clinical integrity of the payment groups and their weights under the OPPS. The Act further specifies that the panel will act in an advisory capacity. The APC Panel, discussed under section I.E.2. of this final rule with comment period, fulfills these requirements. The APC Panel is not restricted to using data compiled by CMS, and it may use data collected or developed by organizations outside the Department in conducting its review.

2. Establishment of the APC Panel

On November 21, 2000, the Secretary signed the initial charter establishing the APC Panel. This expert panel, which may be composed of up to 15 representatives of providers (currently employed full-time, not as consultants, in their respective areas of expertise) subject to the OPPS, reviews clinical data and advises CMS about the clinical integrity of the APC groups and their payment weights. The APC Panel is technical in nature, and it is governed by the provisions of the Federal Advisory Committee Act (FACA). Since its initial chartering, the Secretary has renewed the APC Panel's charter four times: On November 1, 2002; on

November 1, 2004; on November 21, 2006; and on November 2, 2008. (We note that the charter is scheduled to be renewed on or before November 21, 2010.) The current charter specifies, among other requirements, that: The APC Panel continues to be technical in nature; is governed by the provisions of the FACA; may convene up to three meetings per year; has a Designated Federal Official (DFO); and is chaired by a Federal official designated by the Secretary.

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

3. APC Panel Meetings and Organizational Structure

The APC Panel first met on February 27 through March 1, 2001. Since the initial meeting, the APC Panel has held 18 meetings, with the last meeting taking place on August 23–24, 2010. Prior to each meeting, we publish a notice in the **Federal Register** to announce the meeting and, when necessary, to solicit nominations for APC Panel membership and to announce new members.

The APC Panel has established an operational structure that, in part, includes the use of three subcommittees to facilitate its required APC review process. The three current subcommittees are the Data Subcommittee, the Visits and Observation Subcommittee, and the Subcommittee for APC Groups and Status Indicator (SI) Assignments (previously known as the Packaging Subcommittee).

The Data Subcommittee is responsible for studying the data issues confronting the APC Panel and for recommending options for resolving them. The Visits and Observation Subcommittee reviews and makes recommendations to the APC Panel on all technical issues pertaining to observation services and hospital outpatient visits paid under the OPPS (for example, APC configurations and APC payment weights). The Subcommittee for APC Groups and SI Assignments advises the Panel on the following issues: The appropriate SIs to be assigned to HCPCS codes, including but not limited to whether a HCPCS code or a category of codes should be packaged or separately paid; and the appropriate APCs to be assigned to HCPCS codes regarding services for which separate payment is made.

Each of these subcommittees was established by a majority vote from the full APC Panel during a scheduled APC Panel meeting, and the APC Panel recommended that the subcommittees continue at the August 2010 APC Panel meeting. We accept those recommendations of the APC Panel. All subcommittee recommendations are discussed and voted upon by the full APC Panel.

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

F. Summary of the Major Contents of the CY 2011 OPS/ASC Proposed Rule

A proposed rule appeared in the August 3, 2010 **Federal Register** (75 FR 46170) that set forth proposed changes to the Medicare hospital OPPS and the revised Medicare ASC payment system for CY 2011 to implement statutory requirements and changes arising from our continuing experience with the system and to implement certain provisions of Public Law 111–148, as amended by Public Law 111–152 (collectively known as the Affordable Care Act). We proposed quality measures for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) for reporting quality data for annual payment rate updates for CY 2012 and subsequent calendar years, the proposed requirements for data collection and submission for the annual payment update, and a proposed reduction in the OPPS payment for hospitals that fail to meet the HOP QDRP requirements for the CY 2011 payment update, in accordance with the statutory requirement. We also proposed changes to implement provisions of the Affordable Care Act relating to payments to hospitals for direct GME and IME costs and the rules relating to physician self-referrals to hospitals in which they have an ownership or investment interest. In addition, we set forth proposals affecting certain payments under the Medicare IPPS. The following is a summary of the major changes that we proposed to make:

1. Updates Affecting OPPS Payments

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

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

2. OPPS Ambulatory Payment Classification (APC) Group Policies

In section III. of the proposed rule, we discussed—

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

3. OPPS Payment for Devices

In section IV. of the proposed rule, we discussed the proposed pass-through payment for specific categories of

devices and the proposed adjustment for devices furnished at no cost or with partial or full credit.

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

In section V. of the proposed rule, we discussed the proposed CY 2011 OPPS payment for drugs, biologicals, and radiopharmaceuticals, including the proposed payment for drugs, biologicals, and radiopharmaceuticals with and without pass-through status.

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

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

6. OPPS Payment for Brachytherapy Sources

In section VII. of the proposed rule, we discussed our proposal for payment for brachytherapy sources.

7. OPPS Payment for Drug Administration Services

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

8. OPPS Payment for Hospital Outpatient Visits

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

9. Payment for Partial Hospitalization Services

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

10. Procedures That Would Be Paid Only as Inpatient Procedures

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

11. OPPS Nonrecurring Technical and Policy Changes and Clarifications

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

12. OPPS Payment Status and Comment Indicators

In section XIII. of the proposed rule, we discussed our proposed changes to the definitions of status indicators assigned to APCs and present our proposed comment indicators.

13. OPPS Policy and Payment Recommendations

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

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

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

15. Reporting Quality Data for Annual Payment Rate Updates

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

16. Payments to Hospitals for Direct GME and IME Costs

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

17. Physician Self-Referrals to Hospitals

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

18. Regulatory Impact Analysis

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

G. Public Comments Received in Response to the CY 2011 OPPS/ASC Proposed Rule

We received approximately 774 timely pieces of correspondence containing multiple comments on the CY 2011 OPPS/ASC proposed rule that appeared in the **Federal Register** on August 3, 2010. We note that we received some public comments that were outside the scope of the CY 2011 OPPS/ASC proposed rule. These public comments are not addressed in this CY 2011 OPPS/ASC final rule with comment period. Summaries of the public comments that are within the scope of the proposals and our responses to those public comments are set forth in the various sections of this final rule with comment period under the appropriate headings.

H. Public Comments Received on the November 20, 2009 OPPS/ASC Final Rule With Comment Period

We received approximately 18 timely pieces of correspondence on the CY 2010 OPPS/ASC final rule with comment period that appeared in the **Federal Register** on November 20, 2009 (74 FR 60316), some of which contained multiple comments on the interim APC assignments and/or status indicators of HCPCS codes identified with comment indicator "NI" in Addendum B to that final rule with comment period. Summaries of those public comments on topics open to comment in the CY 2010 OPPS/ASC final rule with comment period and our responses to them are set forth in the various sections of this final rule with comment period under the appropriate headings.

I. Interim Final Rule on Certified Registered Nurse Anesthetist (CRNA) Services Furnished in Rural Hospitals and Critical Access Hospitals

Under section XXIII. of this document, we set forth an interim final rule with comment period that changes the effective date for otherwise eligible hospitals and CAHs that have been reclassified from urban to rural status under section 1886(d)(8)(E) of the Act and 42 CFR 412.103 to receive reasonable cost payments for anesthesia services and related care furnished by

nonphysician anesthetists, from cost reporting periods beginning on or after October 1, 2010, to December 2, 2010.

II. Updates Affecting OPPS Payments

A. Recalibration of APC Relative Weights

1. Database Construction

a. Database Source and Methodology

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46179), we proposed to use for CY 2011 the same basic methodology that we described in the November 20, 2009 OPPS final rule with comment period to recalibrate the APC relative payment weights for services furnished on or after January 1, 2011, and before January 1, 2012 (CY 2011). That is, we proposed to recalibrate the relative payment weights for each APC based on claims and cost report data for hospital outpatient department (HOPD) services. We proposed to use the most recent available data to construct the database for calculating APC group weights. Therefore, for the purpose of recalibrating the proposed APC relative payment weights for CY 2011, we used approximately 133 million final action claims for hospital outpatient department services furnished on or after January 1, 2009, and before January 1, 2010. For this final rule with comment period, for the purpose of recalibrating the final APC relative payment weights for CY 2011, we used approximately 145 million final action claims for hospital outpatient department services furnished on or after January 1, 2009, and before January 1, 2010, based on more recent updated data. (For exact counts of claims used, we refer readers to the claims accounting narrative under supporting documentation for the proposed rule and this final rule with comment period on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/HORD/.)*

Of the 145 million final action claims for services provided in hospital outpatient settings used to calculate the CY 2011 OPPS payment rates for this final rule with comment period, approximately 109 million claims were the type of bill potentially appropriate for use in setting rates for OPPS services (but did not necessarily contain services payable under the OPPS). Of the 109 million claims, approximately 4 million claims were not for services paid under the OPPS or were excluded as not appropriate for use (for example, erroneous cost-to-charge ratios (CCRs) or no HCPCS codes reported on the claim). From the remaining 105 million claims, we created approximately 103 million single records, of which approximately 71 million were "pseudo" single or "single session" claims (created from 24 million multiple procedure claims using the process we discuss later in this section). Approximately 792,000 claims were trimmed out on cost or units in excess of +/−3 standard deviations from the geometric mean, yielding approximately 102 million single bills for median setting. As described in section II.A.2. of this final rule with comment period, our data development process is designed with the goal of using appropriate cost information in setting the APC relative weights. The bypass process is described in section II.A.1.b. of this final rule with comment period. This section discusses how we develop "pseudo" single procedure claims (as defined below), with the intention of using more appropriate data from the available claims. In some cases, the bypass process allows us to use some portion of the submitted claim for cost estimation purposes, while the remaining information on the claim continues to be unusable. Consistent with the goal of using appropriate information in our data development process, we only use claims (or portions of each claim) that are appropriate for ratesetting purposes. Ultimately, we were able to use for CY 2011 ratesetting some portion of approximately 95 percent of the CY 2009 claims containing services payable under the OPPS.

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

b. Use of Single and Multiple Procedure Claims

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

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

multiple imaging services for CY 2010, and we proposed to continue to create them for CY 2011. We refer readers to section II.A.2.e. of the proposed rule and this final rule with comment period for discussion of the use of claims to establish median costs for composite APCs.

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

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

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

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

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

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

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

Table 1 published in the CY 2011 OPPS/ASC proposed rule includes the proposed list of bypass codes for CY 2011. As noted in that proposed rule (75 FR 46181), the list of bypass codes contained codes that were reported on claims for services in CY 2009 and, therefore, included codes that were in effect in 2009 and used for billing but were deleted for CY 2010. We retained these deleted bypass codes on the proposed CY 2011 bypass list because these codes existed in CY 2009 and were covered OPD services in that period. Since these bypass codes were deleted for billing in CY 2010, we did not need to retain them for the CY 2010 bypass list. Keeping these deleted bypass codes on the bypass list potentially allowed us to create more "pseudo" single procedure claims for ratesetting purposes. "Overlap bypass codes" that were members of the proposed multiple imaging composite APCs were identified by asterisks (*) in the third column of Table 1 of the proposed rule. HCPCS codes that we proposed to add for CY 2011 also were identified by asterisks (*) in the fourth column of Table 1 of the proposed rule. Table 2 of the proposed rule contained the list of codes that we proposed to remove from the CY 2011 bypass list because they were deleted from the HCPCS before CY 2009. None of these proposed deleted codes were "overlap bypass" codes.

Comment: Several commenters expressed support for the ratesetting methodology using single and "pseudo" single claims and recommended that CMS continue to explore additional methodologies to increase the number of multiple procedure claims used for ratesetting, including expanding the empirical criteria for inclusion on the bypass list. One commenter recommended that CMS examine the bypass list on an annual basis to ensure that the Agency is utilizing as many claims as possible for ratesetting. One commenter supported the proposal to maintain the current radiation oncology procedure codes on the CY 2011 bypass list.

Response: We appreciate the commenters' support. We expect to continue to use our established methodologies and to evaluate additional refinements and improvements to our methodologies, with the goal of achieving appropriate and accurate estimates of the costs of services in the HOPD. We examine the bypass list on an annual basis to ensure that we are using as much information as is available through our claims data.

Comment: One commenter requested that CMS explore alternative methodologies to capture more multiple procedure claims used for future rate setting of composite APC 8001 (LDR Prostate Brachytherapy Composite), noting that a number of multiple procedure claims were not used to model the composite due to containing other payable radiation therapy codes.

Response: As described above, one of the challenges in estimating costs for individual items and services is in how to address the allocation of packaged costs in multiple procedure claims. While we continue to apply the empirical criteria and examine CMS medical advisor and public commenter recommendations in determining additions to the bypass list, we must ensure that the bypass process itself does not improperly allocate packaged costs. We will continue to explore methods through which we might obtain more information from our existing set of claims data.

Comment: Several commenters recommended that CPT codes 93306 (Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography) and 93307 (Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography) be removed from the bypass list. The commenters believed that adding those codes to the bypass list would not appropriately capture costs associated with providing the services. Moreover, they believed that these codes do not meet the criteria for the bypass list. The commenters suggested that hospitals were continuing to bill CPT 93307 in conjunction with CPT codes 93320 (Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete) and 93325 (Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography) rather than using new CY 2009 CPT code 93306 because they were still adjusting to billing with CPT code 93306. They noted that because CPT code 93307 was a proposed addition to the bypass list, the code would not include the packaged costs of CPT codes 93320 and 93325. The commenters also noted that CPT code 93307 did not appear to meet the empirical criteria in the proposed rule claims data. They suggested that, if CMS did not remove CPT code 93307 from the CY 2011 bypass list, claims with combinations of CPT codes 93307, 93320, and 93325 be reconstructed as CPT code 93306 and that the simulated claims be used, together with the claims for CPT code 99306, to set the median costs for CPT code 99306. A few commenters suggested that assigning CPT code 93307 to the same APC as CPT code 93306 was inappropriate because that reassignment was based on the addition of both codes to the bypass list. The commenters also identified APC 0269 (Level II Echocardiogram Without Contrast) as having a 2 times rule violation because, they stated, the median cost of the code with the highest median cost in the APC is more than twice that of the code with the lowest median cost. The application of the 2 times rule is discussed in section III.B.2. of this final rule with comment period. Thus, the commenters recommended that CMS review the coding issues associated with the creation of those codes to ensure that they are not unduly

influencing the respective APC payment rates.

Response: We note that, in the CY 2011 OPPS/ASC proposed rule (75 FR 46180), we described our process for identifying additions to the bypass code list by determining codes that, "using both CY 2010 final rule data (CY 2008 claims) and February 2010 APC Panel data (first 9 months of CY 2009 claims), met the same previously established empirical criteria for the bypass list." However, we wish to clarify that proposed additions to the bypass list were identified by applying the empirical criteria to both sets of data individually. Thus, a code that met the empirical criteria in either of the two sets of claims data would be eligible for addition to the proposed bypass list.

In proposing to add CPT code 93307 to the CY 2011 bypass list, we had examined the single major claims using CY 2010 final rule data, after performing the process described in the CY 2010 OPPS/ASC final rule with comment period to simulate billing for CPT code 93306 (74 FR 60374 through 60376). That is, after we removed the claims that we used to simulate the code configuration for CPT code 93306, we assessed only the remaining claims for CPT code 93307 for the bypass list. When we applied the bypass criteria to these residual final rule claims for CPT code 93307, CPT code 93307 met the empirical criteria and we added it to the proposed rule bypass list. However, when we assessed CPT code 93307 against the CY 2009 claims in the APC Panel data, it did not meet the criteria and, similarly, it does not meet the criteria when assessed against the proposed rule data. Therefore we are accepting the comment, and for the CY 2011 OPPS final rule, we are removing CPT code 93307 from the CY 2011 bypass list. However, we are not creating simulated claims for CPT code 93306 from the claims that report these services using CPT codes 93307, 93320, and 93325 in place of reporting CPT code 93306. We have approximately 765,000 single bills for CPT code 93306, and we see no reason to create simulated median costs for services for which we have adequate cost data from correctly coded claims. We note that, although miscoded claims for CPT code 93306 (that is, CPT code 93307 plus CPT code 93320 plus CPT code 93325) appeared in the data, only CPT code 93307 was paid on these claims because we implemented NCCI edits on January 1, 2009, that stopped CPT codes 93320 and 93325 from being paid if reported with CPT code 93307. Hospitals that reported the service using the three codes instead of reporting CPT code 93306 received payments based on the CY 2009 national unadjusted payment rate of $255.05 for CPT code 93307 rather than a payment based on a national unadjusted payment rate of $431.37 that they would have received if they had reported the correct code for the service.

Regarding the issue of reassignment of CPT code 93307 from APC 0697 (Level I Echocardiogram Without Contrast) to APC 0269, after removing CPT code 93306 from the bypass list, the calculated median cost for CPT code 93306 based on final rule data was approximately $399. The calculated median cost of approximately $399 for CPT code 93306 suggests that the costs of these two procedures are similar. CPT codes 93306 and 93307 would thus meet the APC recalibration standards of clinical and resource homogeneity. Thus, we are finalizing our proposal to assign CPT code 93307 to APC 0269.

As we discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60436), in the determination of APCs that violate the 2 times rule, we apply the 2 times rule to HCPCS codes that are determined to be significant, either based on having a frequency of more than 1,000 single major claims or having both more than 99 single major claims and contributing more than 2 percent of the claims used to determine the APC median cost. Codes that do not meet these criteria as "significant procedures" are not used to determine if there is a 2 times rule violation in an APC. The 2 times rule is discussed in section III.B. of this final rule with comment period.

Comment: One commenter requested that the proposed application of market basket update to the median cost of packaging threshold for the bypass criteria be applied retroactively beginning from CY 2005, when the $50 median packaged cost threshold criterion was first applied.

Response: In the CY 2011 OPPS/ASC proposed rule, we proposed to apply the final market basket update for CY 2009, since it is the most appropriate representation of changes for hospital input prices for CY 2009 and, therefore, most applicable to CY 2009 claims data used to set the CY 2011 OPPS payment rates, to the median packaged cost threshold of $50 established in the CY 2010 OPPS/ASC final rule with comment period (75 FR 46181). We believe that this would ensure that the packaged cost threshold would accurately reflect changes in costs from the prior year. However, we proposed that this market basket adjustment to the packaged cost criterion would apply prospectively. The $50 threshold has historically been an appropriate measure for limiting the impact of redistributing the packaged costs on the multiple procedure claims. We established a criterion of a maximum median amount of packaging of $50 as a means of ensuring that the typical packaging for the service being placed on the bypass list is minimal in amount. With respect to the comment that we apply a market basket update to the median cost of the packaging threshold for the bypass criteria retroactively to CY 2005, we note that, in general, we update our payment rates on a prospective basis and, as explained above, we believe that our proposed and final policy adequately and appropriately accounts for the effects of inflation over time.

Therefore, for the CY 2011 OPPS, we are applying the final CY 2009 market basket update (which is 3.6 percent) to the $50 median packaged cost criterion and rounding the result ($51.80) to the neared $5 increment. Thus, for this CY 2011 OPPS/ASC final rule with comment period, the median cost of packaging criterion for the CY 2011 OPPS bypass list remains at $50.

Comment: One commenter requested that CPT codes 77310 (Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest)) and 77789 (Surface application of radiation source) be added to the bypass list because they believed that these codes meet the bypass criteria. The commenter also suggested that there was a lack of transparency in how the criteria were applied, and that when codes were not added that met the empirical criteria the reasons for doing so should be explained.

Response: Both CPT codes 77310 and 77789 failed to meet the empirical criterion for addition to the bypass list of having 100 or more "natural" single procedure claims in both the APC Panel data and the proposed rule data. Specifically, CPT code 77310 had 0 natural single bills in the CY 2010 final rule data and 2 natural single bills in the CY 2011 APC Panel data; CPT code 77789 had 30 natural single bills in the CY 2010 final rule data and 13 natural single bills in the CY 2011 APC Panel data. As described above, this criterion ensures that we have an adequate base of claims billed for each code so that we can bypass lines with the bypass code from the multiple procedure claims. In addition to failing the number of "natural" single procedure claims criterion, CPT code 77789 failed to meet the percentage of single claims with packaged costs criterion (no more than

5 percent of "natural" single procedure claims can have any packaging) because packaged cost appeared on 6.7 percent of the code's "natural" single major claims in the CY 2010 final rule data and 38.5 percent of the code's "natural" single major claims in the CY 2011 APC Panel data. We are not aware of any codes that met the empirical criteria for addition to the bypass list that are not included on the bypass list.

However, in the course of our review of the comment, we realized that CPT code 77315 (Teletherapy; isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)) meets the empirical criteria and is on the bypass list and that two other CPT codes that are very similar were not on any of the previous bypass code lists. There are three CPT codes for teletherapy, isodose plan, for which CPT code 77315 reports the complex level of service. CPT code 77310, which the commenters requested be added to the bypass list, reports the intermediate level of the service and CPT code 77305 (Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)) reports the simple level of the service. However, neither CPT codes 77305 (simple) nor CPT code 77310 (intermediate) were on any of the previous bypass code lists, notwithstanding that CPT code 77315 meets the empirical criteria and is on the bypass list. Agency clinicians believe that the packaging for CPT codes 77305 and 77310 would be less than for CPT code 77315, because CPT code 77315 represents the most complex level of the service. Moreover, while the "natural" single major claims for CPT codes 77305 (9 claims) and 77310 (6 claims) did not meet the "natural" single major claims criteria of a minimum of 100 claims each in the CY 2011 proposed rule data, they met all other criteria for addition to the bypass list. After consultation with our CMS clinical advisors, we believe that because of the nature of the services and the fact that both codes meet all criteria for the bypass list other than the minimum number of single bills, it is appropriate to add them to the bypass list. We note that, in prior years, we have added low volume services to the bypass list that are similar to requested additions, such as CPT codes for hyperthermia added to the CY 2010 bypass list in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60329). Thus, for this CY 2011 OPPS/ASC final rule with comment period, we are adding CPT codes 77305 and 77310 to the bypass list.

However, CPT code 77789 failed to meet both the "natural" single major claims criterion of 100 natural single procedure claims and greatly exceeded the maximum percentage of single claims with packaging criteria. Specifically, there were only 30 natural single procedure claims and 38.5 percent of the "natural" single procedure claims for CPT code 77789 had packaging and thus failed, by a significant amount, the 5 percent maximum allowable percent of claims with packaging. Therefore, we are not adding the code to the CY 2011 bypass list.

We believe that the empirical criteria described above are transparent and clear, and explain the purpose of each criterion in detail. Moreover we make available our claims data for the public's use in assessing the bypass criteria or any other purpose. We believe the extremely detailed comments we receive on our proposals, such as the comments we received on CPT codes 93306 and 93307, demonstrate that the information we make public is fully sufficient for purposes of analyzing our proposed bypass list. In addition, we have a longstanding practice of adding or removing codes to or from the bypass list through analysis other than application of the empirical criteria. When we do this, we explain our rationale for adding or removing those codes from the bypass list, as we did with the addition of codes for additional hours of drug administration (71 FR 68117 through 68118), which did not meet the empirical criteria but which were added because otherwise we would have had very few claims on which to base the median costs of both initial and additional drug administration services.

We always appreciate the empirical information that commenters submit regarding their suggested additions to the bypass list. However, we note that, due to the redistributive properties of the bypass list and our process for creating "pseudo" single procedure claims, we carefully consider the redistributive impact of additions to the bypass list on all HCPCS code and APC median costs. Future recommendations from the public for additions to the bypass list should consider the global changes to the bypass list in order to facilitate our evaluation of codes suggested for inclusion on the bypass list in the future.

After consideration of the public comments we received, we are adopting as final the proposed "pseudo" single claims process and the final CY 2011 bypass list of 449 HCPCS codes, as displayed in Tables 1 and 2 below. The list has been modified from the CY 2011 proposed list, with the removal of CPT code 93307 from the CY 2011 bypass list and the addition of CPT codes 77305 and 77310, as discussed above in this section.

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

CY 2009 HCPCS code	CY 2009 Short descriptor	"Overlap bypass codes"	Additions
11056	Trim skin lesions, 2 to 4		
11057	Trim skin lesions, over 4		
11300	Shave skin lesion		
11301	Shave skin lesion		
11719	Trim nail(s)		
11720	Debride nail, 1–5		
11721	Debride nail, 6 or more		
11954	Therapy for contour defects		
17000	Destruct premalg lesion		
17003	Destruct premalg les, 2–14		
23600	Treat humerus fracture		*
29220	Strapping of low back		
29530	Strapping of knee		*
31231	Nasal endoscopy, dx		

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

CY 2009 HCPCS code	CY 2009 Short descriptor	"Overlap bypass codes"	Additions
31579	Diagnostic laryngoscopy		
51798	Us urine capacity measure		
53661	Dilation of urethra		
54240	Penis study		
56820	Exam of vulva w/scope		
57150	Treat vagina infection		
57452	Exam of cervix w/scope		*
57454	Bx/curett of cervix w/scope		*
67820	Revise eyelashes		
69210	Remove impacted ear wax		
69220	Clean out mastoid cavity		
70030	X-ray eye for foreign body		
70100	X-ray exam of jaw		
70110	X-ray exam of jaw		
70120	X-ray exam of mastoids		
70130	X-ray exam of mastoids		
70140	X-ray exam of facial bones		
70150	X-ray exam of facial bones		
70160	X-ray exam of nasal bones		
70200	X-ray exam of eye sockets		
70210	X-ray exam of sinuses		
70220	X-ray exam of sinuses		
70240	X-ray exam, pituitary saddle		*
70250	X-ray exam of skull		
70260	X-ray exam of skull		
70320	Full mouth x-ray of teeth		*
70328	X-ray exam of jaw joint		
70330	X-ray exam of jaw joints		
70336	Magnetic image, jaw joint	*	
70355	Panoramic x-ray of jaws		
70360	X-ray exam of neck		
70370	Throat x-ray & fluoroscopy		
70371	Speech evaluation, complex		
70450	Ct head/brain w/o dye	*	
70480	Ct orbit/ear/fossa w/o dye	*	
70486	Ct maxillofacial w/o dye	*	
70490	Ct soft tissue neck w/o dye	*	
70544	Mr angiography head w/o dye	*	
70547	Mr angiography neck w/o dye	*	*
70551	Mri brain w/o dye	*	
71010	Chest x-ray		
71015	Chest x-ray		
71020	Chest x-ray		
71021	Chest x-ray		
71022	Chest x-ray		
71023	Chest x-ray and fluoroscopy		
71030	Chest x-ray		
71034	Chest x-ray and fluoroscopy		
71035	Chest x-ray		
71100	X-ray exam of ribs		
71101	X-ray exam of ribs/chest		
71110	X-ray exam of ribs		
71111	X-ray exam of ribs/chest		
71120	X-ray exam of breastbone		
71130	X-ray exam of breastbone		
71250	Ct thorax w/o dye	*	
72010	X-ray exam of spine		
72020	X-ray exam of spine		
72040	X-ray exam of neck spine		
72050	X-ray exam of neck spine		
72052	X-ray exam of neck spine		
72069	X-ray exam of trunk spine		
72070	X-ray exam of thoracic spine		
72072	X-ray exam of thoracic spine		
72074	X-ray exam of thoracic spine		
72080	X-ray exam of trunk spine		
72090	X-ray exam of trunk spine		
72100	X-ray exam of lower spine		
72110	X-ray exam of lower spine		
72114	X-ray exam of lower spine		

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

CY 2009 HCPCS code	CY 2009 Short descriptor	"Overlap bypass codes"	Additions
72120	X-ray exam of lower spine		
72125	Ct neck spine w/o dye	*	
72128	Ct chest spine w/o dye	*	
72131	Ct lumbar spine w/o dye	*	
72141	Mri neck spine w/o dye	*	
72146	Mri chest spine w/o dye	*	
72148	Mri lumbar spine w/o dye	*	
72170	X-ray exam of pelvis		
72190	X-ray exam of pelvis		
72192	Ct pelvis w/o dye	*	
72202	X-ray exam sacroiliac joints		
72220	X-ray exam of tailbone		
73000	X-ray exam of collar bone		
73010	X-ray exam of shoulder blade		
73020	X-ray exam of shoulder		
73030	X-ray exam of shoulder		
73050	X-ray exam of shoulders		
73060	X-ray exam of humerus		
73070	X-ray exam of elbow		
73080	X-ray exam of elbow		
73090	X-ray exam of forearm		
73100	X-ray exam of wrist		
73110	X-ray exam of wrist		
73120	X-ray exam of hand		
73130	X-ray exam of hand		
73140	X-ray exam of finger(s)		
73200	Ct upper extremity w/o dye	*	
73218	Mri upper extremity w/o dye	*	
73221	Mri joint upr extrem w/o dye	*	
73510	X-ray exam of hip		
73520	X-ray exam of hips		
73540	X-ray exam of pelvis & hips		
73550	X-ray exam of thigh		
73560	X-ray exam of knee, 1 or 2		
73562	X-ray exam of knee, 3		
73564	X-ray exam, knee, 4 or more		
73565	X-ray exam of knees		
73590	X-ray exam of lower leg		
73600	X-ray exam of ankle		
73610	X-ray exam of ankle		
73620	X-ray exam of foot		
73630	X-ray exam of foot		
73650	X-ray exam of heel		
73660	X-ray exam of toe(s)		
73700	Ct lower extremity w/o dye	*	
73718	Mri lower extremity w/o dye	*	
73721	Mri jnt of lwr extre w/o dye	*	
74000	X-ray exam of abdomen		
74010	X-ray exam of abdomen		
74020	X-ray exam of abdomen		
74022	X-ray exam series, abdomen		
74150	Ct abdomen w/o dye	*	
74210	Contrst x-ray exam of throat		
74220	Contrast x-ray, esophagus		
74230	Cine/vid x-ray, throat/esoph		
74246	Contrst x-ray uppr gi tract		
74247	Contrst x-ray uppr gi tract		
74249	Contrst x-ray uppr gi tract		
76100	X-ray exam of body section		
76510	Ophth us, b & quant a		
76511	Ophth us, quant a only		
76512	Ophth us, b w/non-quant a		
76513	Echo exam of eye, water bath		
76514	Echo exam of eye, thickness		
76516	Echo exam of eye		
76519	Echo exam of eye		
76536	Us exam of head and neck		
76645	Us exam, breast(s)		
76700	Us exam, abdom, complete	*	
76705	Echo exam of abdomen	*	

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

CY 2009 HCPCS code	CY 2009 Short descriptor	"Overlap bypass codes"	Additions
76770	Us exam abdo back wall, comp	*	
76775	Us exam abdo back wall, lim	*	
76776	Us exam k transpl w/Doppler	*	
76801	Ob us < 14 wks, single fetus		
76805	Ob us >/= 14 wks, sngl fetus		
76811	Ob us, detailed, sngl fetus		
76816	Ob us, follow-up, per fetus		
76817	Transvaginal us, obstetric		
76830	Transvaginal us, non-ob		
76856	Us exam, pelvic, complete	*	
76857	Us exam, pelvic, limited	*	
76870	Us exam, scrotum	*	
76880	Us exam, extremity		
76970	Ultrasound exam follow-up		
76977	Us bone density measure		
77072	X-rays for bone age		
77073	X-rays, bone length studies		
77074	X-rays, bone survey, limited		
77075	X-rays, bone survey complete		
77076	X-rays, bone survey, infant		
77077	Joint survey, single view		
77078	Ct bone density, axial		
77079	Ct bone density, peripheral		
77080	Dxa bone density, axial		
77081	Dxa bone density/peripheral		
77082	Dxa bone density, vert fx		
77083	Radiographic absorptiometry		
77084	Magnetic image, bone marrow		
77300	Radiation therapy dose plan		
77301	Radiotherapy dose plan, imrt		
77305	Teletx isodose plan simple		
77310	Teletx isodose plan intermediate		
77315	Teletx isodose plan complex		
77327	Brachytx isodose calc interm		
77331	Special radiation dosimetry		
77336	Radiation physics consult		
77370	Radiation physics consult		
77401	Radiation treatment delivery		
77600	Hyperthermia treatment		
77605	Hyperthermia treatment		
77610	Hyperthermia treatment		
78350	Bone mineral, single photon		*
80500	Lab pathology consultation		
80502	Lab pathology consultation		
85097	Bone marrow interpretation		
86510	Histoplasmosis skin test		
86850	RBC antibody screen		
86870	RBC antibody identification		
86880	Coombs test, direct		
86885	Coombs test, indirect, qual		
86886	Coombs test, indirect, titer		
86890	Autologous blood process		
86900	Blood typing, ABO		
86901	Blood typing, Rh (D)		
86903	Blood typing, antigen screen		
86904	Blood typing, patient serum		
86905	Blood typing, RBC antigens		
86906	Blood typing, Rh phenotype		
86930	Frozen blood prep		
86970	RBC pretreatment		
86977	RBC pretreatment, serum		
88104	Cytopath fl nongyn, smears		
88106	Cytopath fl nongyn, filter		
88107	Cytopath fl nongyn, sm/fltr		
88108	Cytopath, concentrate tech		
88112	Cytopath, cell enhance tech		
88160	Cytopath smear, other source		
88161	Cytopath smear, other source		
88162	Cytopath smear, other source		
88172	Cytopathology eval of fna		

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

CY 2009 HCPCS code	CY 2009 Short descriptor	"Overlap bypass codes"	Additions
88173	Cytopath eval, fna, report		
88182	Cell marker study		
88184	Flowcytometry/tc, 1 marker		
88185	Flowcytometry/tc, add-on		
88300	Surgical path, gross		
88302	Tissue exam by pathologist		
88304	Tissue exam by pathologist		
88305	Tissue exam by pathologist		
88307	Tissue exam by pathologist		
88311	Decalcify tissue		
88312	Special stains group 1		
88313	Special stains group 2		
88314	Histochemical stain add-on		*
88321	Microslide consultation		
88323	Microslide consultation		
88325	Comprehensive review of data		
88331	Path consult intraop, 1 bloc		
88342	Immunohistochemistry		
88346	Immunofluorescent study		
88347	Immunofluorescent study		
88348	Electron microscopy		
88358	Analysis, tumor		
88360	Tumor immunohistochem/manual		
88361	Tumor immunohistochem/comput		
88365	Insitu hybridization (fish)		
88368	Insitu hybridization, manual		
89049	Chct for mal hyperthermia		
89230	Collect sweat for test		
89240	Pathology lab procedure		
90472	Immunization admin, each add		
90474	Immune admin oral/nasal addl		
90801	Psy dx interview		
90802	Intac psy dx interview		
90804	Psytx, office, 20–30 min		
90805	Psytx, off, 20–30 min w/e&m		
90806	Psytx, off, 45–50 min		
90807	Psytx, off, 45–50 min w/e&m		
90808	Psytx, office, 75–80 min		
90809	Psytx, off, 75–80 min, w/e&m		
90810	Intac psytx, off, 20–30 min		
90811	Intac psytx, 20–30 min, w/e&m		
90812	Intac psytx, off, 45–50 min		
90816	Psytx, hosp, 20–30 min		
90818	Psytx, hosp, 45–50 min		
90826	Intac psytx, hosp, 45–50 min		
90845	Psychoanalysis		
90846	Family psytx w/o patient		
90847	Family psytx w/patient		
90853	Group psychotherapy		
90857	Intac group psytx		
90862	Medication management		
92002	Eye exam, new patient		
92004	Eye exam, new patient		
92012	Eye exam established pat		
92014	Eye exam & treatment		
92020	Special eye evaluation		
92025	Corneal topography		
92060	Special eye evaluation		*
92081	Visual field examination(s)		
92082	Visual field examination(s)		
92083	Visual field examination(s)		
92135	Ophth dx imaging post seg		
92136	Ophthalmic biometry		
92225	Special eye exam, initial		
92226	Special eye exam, subsequent		
92230	Eye exam with photos		
92240	Icg angiography		
92250	Eye exam with photos		
92275	Electroretinography		
92285	Eye photography		

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

CY 2009 HCPCS code	CY 2009 Short descriptor	"Overlap bypass codes"	Additions
92286	Internal eye photography		
92520	Laryngeal function studies		
92541	Spontaneous nystagmus test		
92542	Positional nystagmus test		*
92546	Sinusoidal rotational test		
92548	Posturography		
92552	Pure tone audiometry, air		
92553	Audiometry, air & bone		
92555	Speech threshold audiometry		
92556	Speech audiometry, complete		
92557	Comprehensive hearing test		
92567	Tympanometry		
92582	Conditioning play audiometry		
92585	Auditor evoke potent, compre		
92603	Cochlear implt f/up exam 7 >		
92604	Reprogram cochlear implt 7 >		
92626	Eval aud rehab status		
93005	Electrocardiogram, tracing		
93017	Cardiovascular stress test		
93225	ECG monitor/record, 24 hrs		
93226	ECG monitor/report, 24 hrs		
93231	Ecg monitor/record, 24 hrs		
93232	ECG monitor/report, 24 hrs		
93236	ECG monitor/report, 24 hrs		
93270	ECG recording		
93271	Ecg/monitoring and analysis		
93278	ECG/signal-averaged		
93279	Pm device progr eval, sngl		*
93280	Pm device progr eval, dual		*
93281	Pm device progr eval, multi		*
93282	Icd device progr eval, 1 sngl		*
93283	Icd device progr eval, dual		*
93284	Icd device progr eval, mult		*
93285	Ilr device eval progr		*
93288	Pm device eval in person		*
93289	Icd device interrogate		*
93290	Icm device eval		*
93291	Ilr device interrogate		*
93292	Wcd device interrogate		*
93293	Pm phone r-strip device eval		*
93296	Pm/icd remote tech serv		*
93306	Tte w/doppler, complete		*
93786	Ambulatory BP recording		
93788	Ambulatory BP analysis		
93797	Cardiac rehab		
93798	Cardiac rehab/monitor		
93875	Extracranial study		
93880	Extracranial study		
93882	Extracranial study		
93886	Intracranial study		
93888	Intracranial study		
93922	Extremity study		
93923	Extremity study		
93924	Extremity study		
93925	Lower extremity study		
93926	Lower extremity study		
93930	Upper extremity study		
93931	Upper extremity study		
93965	Extremity study		
93970	Extremity study		
93971	Extremity study		
93975	Vascular study		
93976	Vascular study		
93978	Vascular study		
93979	Vascular study		
93990	Doppler flow testing		
94015	Patient recorded spirometry		
94690	Exhaled air analysis		
95115	Immunotherapy, one injection		
95117	Immunotherapy injections		

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

CY 2009 HCPCS code	CY 2009 Short descriptor	"Overlap bypass codes"	Additions
95165	Antigen therapy services		
95250	Glucose monitoring, cont		
95805	Multiple sleep latency test		
95806	Sleep study unatt & resp efft		
95807	Sleep study, attended		
95808	Polysomnography, 1–3		
95812	Eeg, 41–60 minutes		
95813	Eeg, over 1 hour		
95816	Eeg, awake and drowsy		
95819	Eeg, awake and asleep		
95822	Eeg, coma or sleep only		
95869	Muscle test, thor paraspinal		
95872	Muscle test, one fiber		
95900	Motor nerve conduction test		
95921	Autonomic nerv function test		
95925	Somatosensory testing		
95926	Somatosensory testing		
95930	Visual evoked potential test		
95950	Ambulatory eeg monitoring		
95953	EEG monitoring/computer		
95970	Analyze neurostim, no prog		
95972	Analyze neurostim, complex		
95974	Cranial neurostim, complex		
95978	Analyze neurostim brain/1h		
96000	Motion analysis, video/3d		
96101	Psycho testing by psych/phys		
96111	Developmental test, extend		
96116	Neurobehavioral status exam		
96118	Neuropsych tst by psych/phys		
96119	Neuropsych testing by tec		
96150	Assess hlth/behave, init		
96151	Assess hlth/behave, subseq		
96152	Intervene hlth/behave, indiv		
96153	Intervene hlth/behave, group		
96361	Hydrate iv infusion, add-on		*
96366	Ther/proph/diag iv inf addon		*
96367	Tx/proph/dg addl seq iv inf		*
96370	Sc ther infusion, addl hr		*
96371	Sc ther infusion, reset pump		*
96375	Tx/pro/dx inj new drug addon		*
96402	Chemo hormon antineopl sq/im		
96411	Chemo, iv push, addl drug		
96415	Chemo, iv infusion, addl hr		
96417	Chemo iv infus each addl seq		
96423	Chemo ia infuse each addl hr		
96900	Ultraviolet light therapy		
96910	Photochemotherapy with UV–B		
96912	Photochemotherapy with UV–A		
96913	Photochemotherapy, UV–A or B		
96920	Laser tx, skin < 250 sq cm		
98925	Osteopathic manipulation		
98926	Osteopathic manipulation		
98927	Osteopathic manipulation		
98940	Chiropractic manipulation		
98941	Chiropractic manipulation		
98942	Chiropractic manipulation		
99203	Office/outpatient visit, new		*
99204	Office/outpatient visit, new		
99212	Office/outpatient visit, est		
99213	Office/outpatient visit, est		
99214	Office/outpatient visit, est		
99241	Office consultation		
99242	Office consultation		
99243	Office consultation		
99244	Office consultation		
99245	Office consultation		
99406	Behav chng smoking 3–10 min		*
99407	Behav chng smoking > 10 min		*
0144T	CT heart wo dye; qual calc		
G0008	Admin influenza virus vac		

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

CY 2009 HCPCS code	CY 2009 Short descriptor	"Overlap bypass codes"	Additions
G0101	CA screen; pelvic/breast exam		
G0127	Trim nail(s)		
G0130	Single energy x-ray study		
G0166	Extrnl counterpulse, per tx		
G0175	OPPS Service,sched team conf		
G0248	Demonstrate use home inr mon		*
G0249	Provide INR test mater/equip		*
G0340	Robt lin-radsurg fractx 2–5		
G0365	Vessel mapping hemo access		
G0389	Ultrasound exam AAA screen		
G0390	Trauma Respons w/hosp criti		
G0402	Initial preventive exam		*
G0404	EKG tracing for initial prev		*
M0064	Visit for drug monitoring		
Q0091	Obtaining screen pap smear		

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

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

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46195), we proposed to continue for CY 2011 to use the hospital-specific overall ancillary and departmental CCRs to convert charges to estimated costs through application of a revenue code-to-cost center crosswalk. To calculate the APC median costs on which the proposed CY 2011 APC payment rates were based, we calculated hospital-specific overall ancillary CCRs and hospital-specific departmental CCRs for each hospital for which we had CY 2009 claims data from the most recent available hospital cost reports, in most cases, cost reports beginning in CY 2008. For the CY 2011 OPPS proposed rates, we used the set of claims processed during CY 2009. We applied the hospital-specific CCR to the hospital's charges at the most detailed level possible, based on a revenue code-to-cost center crosswalk that contains a hierarchy of CCRs used to estimate costs from charges for each revenue code. That crosswalk is available for review and continuous comment on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage.*

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

We calculated CCRs for the standard and nonstandard cost centers accepted by the electronic cost report database. In general, the most detailed level at which we calculated CCRs was the hospital-specific departmental level. For a discussion of the hospital-specific overall ancillary CCR calculation, we refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 67983 through 67985). One longstanding exception to this general methodology for calculation of CCRs used for converting charges to costs on each claim is the calculation of median blood costs, as discussed in section II.A.2.d.(2) of the proposed rule and this final rule with comment period and which has been our standard policy since the CY 2005 OPPS.

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

We then calculated the CCRs for each cost center and the overall ancillary CCR for each hospital for which we had claims data. We did this using hospital-specific data from the Hospital Cost

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

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

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

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

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

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

In the CY 2009 OPPS/ASC final rule with comment period, we indicated that we would be making some OPPS-specific changes in response to the RTI report recommendations. Specifically, these changes included modifications to the cost reporting software and the addition of three new nonstandard cost centers. With regard to modifying the cost reporting preparation software in order to offer additional descriptions for nonstandard cost centers to improve the accuracy of reporting for nonstandard cost centers, we indicated that the change would be made for the next release of the cost report software. These changes have been made to the cost reporting software with the implementation of CMS Transmittal 21, under Chapter 36 of the Provider Reimbursement Manual—Part II, available online at *http://www.cms.hhs.gov/Manuals/PBM/*, which is effective for cost reporting periods ending on or after October 1, 2009.

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

Furthermore, we noted in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43781 through 43782) that we were updating the cost report form to eliminate outdated requirements, in conjunction with the Paperwork Reduction Act (PRA), and that we had proposed actual changes to the cost reporting form, the attending cost reporting software, and the cost report instructions in Chapters 36 and 40 of the PRM–II. The new draft hospital cost report Form CMS–2552–10

was published in the **Federal Register** on July 2, 2009, and was subject to a 60-day review and comment period, which ended on August 31, 2009. We received numerous comments on the draft hospital cost report Form CMS–2552–10, specifically regarding the creation of new cost centers from which data might be used in the OPPS cost-based relative weights calculation. We proposed to create new standard cost centers for Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Cardiac Catheterization in Form CMS–2552–10. We also stated that if these standard cost centers are finalized, when the data become available, we would analyze the cost and charge data to determine if it is appropriate to use those data to create distinct CCRs from these cost centers in setting the relative weights. For a discussion of these cost centers, we refer readers to the FY 2011 IPPS/LTCH PPS final rule (75 FR 50075 through 50080). Comments will be addressed in detail in the **Federal Register** notice that will finalize Form CMS–2552–10. The revised draft of hospital cost report Form CMS–2552–10 went on public display on April 23, 2010, and appeared in the **Federal Register** on April 30, 2010 (75 FR 22810) with a 30-day public comment period. The public comment period ended on June 1, 2010. We believe that improved cost report software, the incorporation of new standard and nonstandard cost centers, and the elimination of outdated requirements will improve the accuracy of the cost data contained in the electronic cost report data files and, therefore, the accuracy of our cost estimation processes for the OPPS relative weights. We will continue our standard practice of examining ways in which we can improve the accuracy of our cost estimation processes.

Comment: One commenter noted that Medicare cost report data show that there is still much confusion about how hospitals should report the costs of large imaging equipment. Consequently, the commenter recommended that CMS delay implementation of the new CT and MRI cost center data until the cost reports reflect at least 90 percent of CT and MRI capital costs, based on a comparison to industry average equipment purchases. Some commenters requested that CMS delay establishing the new standard cost centers for CT and MRI until the causes of the associated payment distortions are understood and cost reporting is improved to more properly allocate large capital costs. The commenters requested more careful analysis of the impact of creating the cost centers because of the payment impacts on other Medicare payment systems. Several commenters encouraged CMS to continue monitoring the reporting of CT and MRI capital costs over the next few years. Some commenters recommended that CMS provide explicit, unambiguous guidance to hospitals on how to improve allocation of the large capital costs of imaging equipment directly to the new MRI or CT cost centers. Several commenters supported the decision to establish a standard cost center for cardiac catheterization but did not support the creation of cost centers for CT and MRI. Other commenters asked that CMS ensure that all hospitals are fully educated about the cost center requirements, ensure that the cost centers are implemented in a timely manner, and validate the accuracy of the data produced by the new cost centers to ensure that they are correct and result in more accurate ratesetting. They did not support use of the resulting cost center data at the departmental level for ratesetting until after CMS has produced information on the impact of the use of such data.

Response: We understand the commenters' statements regarding the challenges and difficulties in appropriately reporting the cost and charge data accurately for these standard cost centers. We responded to these concerns in the FY 2011 IPPS/LTCH final rule, including the treatment of CT and MRI equipment costs as "major moveable equipment" rather than as a "building equipment cost," our goal of obtaining more accurate data in creating these new standard cost centers, the application of these standard cost centers only for those hospitals who maintain distinct departments or accounts in their internal accounting systems for CT scanning, MRI or cardiac catheterization, and other concerns (75 FR 50076 through 50080). However, we note that hospitals have been responsible for properly reporting the cost of the equipment and facilities that are necessary to furnish services for the many years since the inception of the Medicare program and that the creation of cost centers for CT, MRI, and cardiac rehabilitation does not alter the fundamental principles of cost reporting to which hospitals have been and remain bound and for which they should follow the instructions in the Medicare Provider Reimbursement Manual.

In the FY 2011 IPPS/LTCH PPS final rule (75 FR 50080), we finalized a policy of establishing standard cost centers for CT scanning, MRI scans, and cardiac catheterization. This policy required hospitals that furnish these services and maintain distinct departments or accounts in their internal accounting systems for them to report the costs and charges under the new cost centers on the revised Medicare cost report Form CMS 2552–10 for cost report periods beginning on or after May 1, 2010. We established these standard cost centers because we believe that we should collect cost and charge data for these areas, and use those data to assess the resulting CCRs specific to CT scanning and MRI services as a possible means of eliminating aggregation bias for these and other radiology services in the IPPS and the OPPS. We believe that establishing these standard cost centers is necessary to improving the accuracy of estimating costs for imaging services and will allow us to perform the impact assessment that some commenters want us to do.

In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23880) and the CY 2011 OPPS/ASC proposed rule (75 FR 46196), we noted that there is typically a 3-year lag between the availability of the cost report data that we use to calculate the relative weights both under the IPPS and the OPPS and a given fiscal or calendar year, and therefore the data from the standard cost centers for CT scans, MRI, and cardiac catheterization respectively, should they be finalized, would not be available for possible use in calculating the relative weights earlier than 3 years after Form CMS–2552–10 becomes available. At that time, we would analyze the data and determine if it is appropriate to use those data to create distinct CCRs from these cost centers for use in the relative weights for the respective payment systems. Therefore, we wish to reassure the commenters that there is no need for immediate concern regarding possible negative payment impacts on MRI and CT scans under the IPPS and the OPPS. We will first thoroughly analyze and run impacts on the data and provide the public with the opportunity to comment, as usual, before distinct CCRs for MRI and CT scans would be finalized for use in the calculation of the relative weights. Our decision to finalize our proposal regarding cost centers for these services is only the first step to a longer process during which we will continue to consider public comment.

Comment: One commenter expressed concern over potential payment changes for cryoablation probes as a result of the cost center creation of "Implantable Devices Charged to Patients" and how hospitals bill for them. The commenter stated that claims data show hospitals typically billing for cryoablation probes using revenue code 0272 (Medical/

Surgical Supplies; Sterile Supplies) rather than revenue code 0278 (Medical/Surgical Supplies; Other Implants). The commenter requested that interim payment measures regarding how the rates are calculated be considered until the data demonstrates appropriate revenue assignment of the devices into revenue code 0278, suggesting that, in the event that payment for the probes decreases, hospitals may elect not to provide the service.

Response: In the FY 2009 IPPS final rule (73 FR 48458 through 48467), we explained in detail the reasoning behind the development of the cost center split for the "Medical Supplies Charged to Patients" cost center and our decision to ultimately have hospitals use the American Hospital Association's National Uniform Billing Committee (NUBC) revenue codes to determine what would be reported in the "Medical Supplies Charged to Patients" and the "Implantable Devices Charged to Patients" cost centers. In that discussion, we noted that while we require that the device broadly be considered implantable to have its costs and charges included in the new "Implantable Devices Charged to Patients" cost center, our final policy did not require the device to remain in the patient at discharge (73 FR 48462 through 48463). In response to comments on our proposal to create the new cost center in the FY 2009 IPPS final rule, we did define the new "Implantable Devices Charged to Patients" cost center by the revenue codes that we believe would map to this cost center to facilitate ease of reporting by hospitals. We note that revenue code definitions are established by the NUBC, and we fully expect hospitals to follow existing guidelines regarding revenue code use. As we stated in the CY 2010 OPPS/ASC final rule with comment period, with regard to reporting cryoablation probes, we do not believe that the current NUBC definition of revenue code 0278 (Medical/Surgical Supplies and Devices (also see 062x, an extension of 027x); Other implants (a)) precludes reporting hospital charges for cryoablation probes under this revenue code (74 FR 60344). Therefore, we believe hospitals can report charges for cryoablation probes under the revenue code 0278 using the definitions in the official UB–04 Data Specifications Manual.

In the FY 2009 IPPS final rule, we noted that using existing revenue codes and definitions as they have been currently established by the NUBC made sense, as the definitions have been in place for some time and are used across all payors (73 FR 48461). Further, we noted that that methodology and the accuracy of the relative weights are heavily dependent upon hospitals' reporting practices. Nothing precludes a hospital that currently reports charges for cryoablation probes under revenue code 0272 from changing the revenue code under which it reports charges for cryoablation probes to revenue code 0278 or otherwise, if it determines that doing so would result in more appropriate payment for the service.

While CMS is responsible for issuing cost reporting instructions that are clear, hospitals are responsible for ensuring that their cost reporting and billing practices are consistent and conform to Medicare policy. We fully expect providers to follow existing guidelines regarding revenue code use, and we see no basis on which to make payment on a basis other than the standard OPPS methodology. Therefore, we are not adopting an interim payment measure in the median cost calculation of cryoablation probes.

Comment: One commenter requested that CMS acknowledge current payment inaccuracies for Magnetoencephalography (MEG), also known as Magnetic Source Imaging. The commenter asked CMS to create a cost center on the Medicare cost report that would be used solely to capture hospitals' costs of MEG and indicated that the NUBC had approved a request for a dedicated revenue code for the reporting of charges for MEG. The commenter argued that if CMS would create a cost center for the costs of MEG from which a specific CCR could be developed for application to MEG charges, the resulting median cost would be a more accurate reflection of the cost of MEG and would, therefore, result in more appropriate payment. The commenter suggested that, based on previous experience where subscripted lines created for MEG identified significantly different CCRs for the service, there was evidence that the current methodology of calculating payment for MEG was flawed.

Response: We disagree that a new cost center is needed to capture the costs of MEG. Over the past several years, we have either proposed or discussed potential new standard and nonstandard cost centers for the Medicare hospital cost report in our 2008, 2009, and 2010 hospital inpatient and outpatient final rules. All of the potential cost centers that we have discussed for addition to the cost report, whether standard or nonstandard, have demonstrated volume in the electronic hospital cost report data. In its July 2008 report on using cost report data to estimate costs for both the IPPS and OPPS (*http://www.rti.org/reports/cms/*), RTI International examined the electronic hospital cost report database and recommended new standard and nonstandard cost centers on the basis of reporting volume across hospitals. RTI International typically identified no fewer than 200 institutions reporting a specific service category, such as cardiac catheterization or cardiac rehabilitation, in subscripted or other lines for the new nonstandard and standard cost centers. Historically, our rationale for adding official nonstandard cost centers to the cost report has been at the request of Medicare contractors experiencing a significant volume of requests for a cost center for a specific type of service.

In contrast, the volume of MEG services is extremely low. In the hospital outpatient CY 2010 OPPS claims data, hospitals reported 131 units of MEG spread among the three CPT codes for MEG among the three CPT codes for MEG: 52 units of CPT code 95965 (Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (*e.g.* epileptic cerebral cortex localization)); 39 units of CPT code 95966 (Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (*e.g.* epileptic cerebral cortex localization) for evoked magnetic fields, single modality (*e.g.* sensory, motor, language or visual cortex localization)); and 40 units of CPT code 95967 (Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (*e.g.* epileptic cerebral cortex localization), for evoked magnetic fields, each additional modality (*e.g.* sensory, motor language, or visual cortex localization (List separately in addition to code for primary procedure))). This continues the pattern of low volumes of the total of the 3 MEG codes that have been reported in the outpatient setting since the creation of the codes in CY 2005 (39 in CY 2005, 75 in CY 2006, 102 units in CY 2007, 75 units in 2008, 131 units in 2009). Moreover in CY 2009, only 13 hospitals reported CPT code 95965, the highest volume of the 3 MEG codes. We do not believe that it is necessary to create a cost center for a service for which so few providers furnish so few services in a year. We recognize that our claims data show only Medicare hospital outpatient billings and that there are likely to be more MEG services that are furnished to Medicare beneficiaries who are in covered inpatient stays and to patients who are not Medicare beneficiaries. However,

the extremely low volume of claims for MEG services furnished to Medicare beneficiaries in the hospital outpatient setting and the extremely low number of hospitals that report these codes relative to the volumes we typically have considered in adding both standard and nonstandard cost centers to the cost report lead us to conclude that a specific cost center for MEG is not justified at this time.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to continue to assign CPT code 95965 (which has a CPT level median of approximately $2,521) to APC 0067, with a final CY 2010 APC median cost of approximately $3,272, on which payment will be based, and to continue to assign CPT codes 95966 (which has a CPT level median of approximately $1,632) and 96967 (which has a CPT level median of approximately $1,415) to APC 0065, with a final CY 2010 APC median cost of approximately $967, on which the payment will be based.

2. Data Development Process and Calculation of Median Costs

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

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

a. Claims Preparation

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

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

We divided the remaining claims into the three groups shown below. Groups 2 and 3 comprise the 110 million claims that contain hospital bill types paid under the OPPS.

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

2. Claims that were bill types 12X, 13X or 14X. Claims with bill types 12X and 13X are hospital outpatient claims. Claims with bill type 14X are laboratory specimen claims, of which we use a subset for the limited number of services in these claims that are paid under the OPPS.

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

To convert charges on the claims to estimated cost, we multiplied the charges on each claim by the appropriate hospital specific CCR associated with the revenue code for the charge as discussed in section II.A.1.c. of this final rule with comment period. We then flagged and excluded CAH claims (which are not paid under the OPPS) and claims from hospitals with invalid CCRs. The latter included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from hospitals with obviously erroneous CCRs (greater than 90 or less than 0.0001); and those from hospitals with overall ancillary CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs). In addition, we trimmed the CCRs at the cost center (that is, departmental) level by removing the CCRs for each cost center as outliers if they exceeded +/− 3 standard deviations from the geometric mean. We used a four-tiered hierarchy of cost center CCRs, which is the revenue code-to-cost center crosswalk, to match a cost center to every possible revenue code appearing in the outpatient claims that is relevant to OPPS services, with the top tier being the most common cost center and the last tier being the default CCR. If a hospital's cost center CCR was deleted by trimming, we set the CCR for that cost center to "missing" so that another cost center CCR in the revenue center hierarchy could apply. If no other cost center CCR could apply to the revenue code on the claim, we used the hospital's overall ancillary CCR for the revenue code in question as the default CCR. For example, if a visit was reported under the clinic revenue code but the hospital did not have a clinic cost center, we mapped the hospital-specific overall ancillary CCR to the clinic revenue code. The revenue code-to-cost center crosswalk is available for inspection and comment on the CMS Web site: *http://www.cms.gov/HospitalOutpatientPPS.* Revenue codes that we do not use to set medians or to model impacts are identified with an "N" in the revenue code-to-cost center crosswalk.

At the February 17–18, 2010 APC Panel Meeting, the Panel recommended that CMS present to the Data Subcommittee an analysis of the effect of using a different lower-level threshold in the overall CCR error trim as part of the standard methodology. The Panel members were concerned that our current CCR trimming policy (excluding providers with an overall ancillary CCR greater than 90 or less than 0.0001 or above and then excluding remaining providers with overall ancillary CCRs beyond +/− 3 standard deviations from the geometric mean) could result in the exclusion of

claims from providers that could otherwise be used for ratesetting and modeling. As we indicated in the proposed rule (75 FR 46198), we accepted this recommendation. At the August 23–24, 2010 APC Panel meeting, we provided the Data Subcommittee with an analysis that displayed the number of hospitals trimmed by our current process for removing hospitals based on aberrant overall ancillary CCRs, as well as our assessment of the impact if we were to use the error CCR thresholds established by the IPPS of less than 0.01 and greater than 10.0 (75 FR 50136). Specifically, we found that, using our current trimming methodology, we trimmed out data from 36 hospitals due to having error CCRs, while we trimmed data from 61 hospitals because they have CCRs that were outside 3 standard deviations from the geometric mean. When we applied the IPPS tolerances, we found that we would trim out data from 46 hospitals due to having error CCRs, while we would trim data from 57 hospitals due to the outlier trim (beyond +/−3 standard deviations from the geometric mean). The slight change between the numbers occurs because changing the error CCR trim to match the IPPS tolerances shifts hospitals from being trimmed based on the outlier trim to being trimmed based on the error trim. The standard outlier trim is more significant in removing data from hospitals with aberrant CCRs because it ensures that our claims data are accurately reflective of hospitals under the OPPS, independent of the actual numeric values of the CCRs. Observing that the number of hospitals whose data were removed based on the error CCR trim was limited, that a more significant number of hospitals were trimmed by the standard trim of three standard deviations beyond the geometric mean, and that the impact of adopting the IPPS CCR tolerances had minimal impact on a small subset of APCs, the Data Subcommittee recommended that CMS continue to use the current error CCR thresholds of 0.0001 and 90.

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

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

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

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

To implement our policy adopted in this final rule with comment period to redistribute some portion of total cost of packaged drugs and biologicals to the separately payable drugs and biologicals as acquisition and pharmacy overhead and handling costs discussed in section V.B.3. of this final rule with comment period, we used the line-item cost data for drugs and biologicals for which we had a HCPCS code with ASP pricing information to calculate the ASP+X values, first for all drugs and biologicals, and then for separately payable drugs and biologicals and for packaged drugs and biologicals, respectively, by taking the ratio of total claim cost for each group relative to total ASP dollars (per unit of each drug or biological HCPCS code's July 2010 ASP amount multiplied by total units for each drug or biological in the CY 2009 claims data). These values are ASP+13 percent (for all drugs and biologicals with HCPCS codes, whether separately paid or packaged), ASP–1 percent (for drugs and biologicals that are separately paid), and ASP+296 percent (for drugs and biologicals that have HCPCS codes and that are packaged), respectively. As we discuss in section V.B.3. of this final rule with comment period, as we proposed, in this final rule with comment period, we are redistributing $150 million of the total cost in our claims data for packaged drugs and biologicals that have an associated ASP from packaged drugs with an ASP to separately payable drugs and biologicals. As we also proposed, in this final rule with comment period, we are redistributing an additional $50 million of the total cost in our claims data for drugs and biologicals lacking an ASP, largely for estimated costs associated with uncoded charges billed under pharmacy revenue code series 025X (Pharmacy (also see 063X, an extension of 025X)), 026X (IV Therapy), and 063X (Pharmacy—Extension of 025X). We observe approximately $652 million for packaged drugs lacking a HCPCs code and an ASP in our CY 2009 claims data. This total excludes the cost of diagnostic and therapeutic radiopharmaceuticals because they are not reported under pharmacy revenue codes or under the pharmacy cost center on the hospital cost report.

Removing a total of $150 million in pharmacy overhead cost from packaged drugs and biologicals reduces the $612 million cost of packaged drugs and biologicals with HCPCS codes and ASPs to $462 million, approximately a 25-percent reduction. Removing $50 million from the cost of drugs lacking an ASP reduces the $652 million to $602 million, approximately an 8-percent reduction. To implement our CY 2011 policy adopted in this final rule with comment period to redistribute $150 million in claim cost from packaged drugs and biologicals with an ASP to separately payable drugs and biologicals and $50 million in claim cost from packaged drugs and biologicals lacking an ASP, including uncoded pharmacy revenue code charges, we multiplied the cost of each packaged drug or biological with a HCPCS code and ASP pricing information in our CY 2009 claims data by 0.75, and we multiplied all other packaged drug costs in our CY 2009 claims data, excluding those for diagnostic radiopharmaceuticals, by 0.92. We also added the redistributed $200 million to the total cost of separately payable drugs and biologicals in our CY 2009 claims data, which increased the relationship between the total cost for separately payable drugs and biologicals and ASP dollars for the same drugs and biologicals from ASP–1 percent to ASP+5 percent. We refer readers to section V.B.3. of this final rule with comment period for a complete discussion of our policy to pay for separately paid drugs and biologicals and pharmacy overhead for CY 2011.

We then removed line-items that were not paid during claim processing, presumably for a line-item rejection or denial. We added this process to our median cost calculation methodology for the CY 2010 OPPS, as discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60359). The number of edits for valid OPPS payment in the Integrated Outpatient Code Editor (I/OCE) and elsewhere has grown significantly in the past few years, especially with the implementation of

the full spectrum of National Correct Coding Initiative (NCCI) edits. To ensure that we are using valid claims that represent the cost of payable services to set payment rates, we removed line-items with an OPPS status indicator for the claim year and a status indicator of "S," "T," "V," or "X" when separately paid under the prospective year's payment system. This logic preserves charges for services that would not have been paid in the claim year but for which some estimate of cost is needed for the prospective year, such as services newly proposed to come off the inpatient list for CY 2010 that were assigned status indicator "C" in the claim year. It also preserves charges for packaged services so that the costs can be included in the cost of the services with which they are reported, even if the CPT codes for the packaged services were not paid because the service is part of another service that was reported on the same claim or the code otherwise violates claims processing edits.

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

Comment: One commenter requested that CMS conduct analysis of the overall CCR error trim in 2010 and provide APC-specific impacts for all radiation oncology services. The commenter also recommended that CMS consider implementation of a lower-level threshold for the CCR error trim in future rulemaking.

Response: As we noted above, the impact of moving the lower-level error CCR threshold is minimal because of its interaction with the standard trim of all hospitals whose overall ancillary CCR is three standard deviations beyond the geometric mean. Established tolerances of 0.0001 and 90 remove those hospitals whose CCRs are highly aberrant relative to the others in the data set, in particular because they apply at the hospital level and not at the departmental level. While the commenter has requested that we conduct an analysis of the impact of the overall CCR error trim on the APCs for radiation oncology, we note that this standard error CCR trim is intended to remove all claims (not limited to a particular category of care) from hospitals with highly aberrant CCRs so that the relativity of the APC payment weights is accurate. Therefore, the impact on selected APCs, such as radiation oncology APCs, is not relevant to a determination of whether a hospital's overall CCR is so extreme that all claims for the hospital should be excluded from the data on which the OPPS relative weights are based. We will continue to monitor whether our established error CCR thresholds are appropriate. However, based on the recent study we provided to the APC Panel Data Subcommittee, we agree with the Panel's assessment that the current error CCR tolerances are appropriate.

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

(1) Splitting Claims

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

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

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

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

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

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

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

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

We did not receive any public comments on our proposed process of organizing claims by type. Therefore, for the reasons set forth in the proposed rule (75 CFR 46199), we are finalizing our CY 2011 proposal without modification.

(2) Creation of "Pseudo" Single Procedure Claims

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

As proposed, for this final rule with comment period, we also used the bypass codes listed earlier in Table 1 and discussed in section II.A.1.b. of this final rule with comment period to remove separately payable procedures that we determined contained limited or no packaged costs or that were otherwise suitable for inclusion on the bypass list from a multiple procedure bill. As discussed above, we ignore the "overlap bypass codes," that is, those HCPCS codes that are both on the bypass list and are members of the multiple imaging composite APCs, in this initial assessment for "pseudo" single procedure claims. The CY 2011 "overlap bypass codes" are listed in Table 1 in section II.A.1.b. of this final rule with comment period. When one of the two separately payable procedures on a multiple procedure claim was on the bypass list, we split the claim into two "pseudo" single procedure claim records. The single procedure claim record that contained the bypass code did not retain packaged services. The single procedure claim record that contained the other separately payable procedure (but no bypass code) retained the packaged revenue code charges and the packaged HCPCS code charges. We also removed lines that contained multiple units of codes on the bypass list and treated them as "pseudo" single procedure claims by dividing the cost for the multiple units by the number of units on the line. Where one unit of a single, separately payable procedure code remained on the claim after removal of the multiple units of the bypass code, we created a "pseudo" single procedure claim from that residual claim record, which retained the costs of packaged revenue codes and packaged HCPCS codes. This enabled us to use claims that would otherwise be multiple procedure claims and could not be used.

As proposed, for this final rule with comment period, we then assessed the claims to determine if the criteria for the multiple imaging composite APCs, discussed in section II.A.2.e.(5) of this final rule with comment period, were met. Where the criteria for the imaging composite APCs were met, we created a "single session" claim for the applicable imaging composite service and determined whether we could use the claim in ratesetting. For HCPCS codes that are both conditionally packaged and are members of a multiple imaging composite APC, we first assessed whether the code would be packaged and, if so, the code ceased to be available for further assessment as part of the composite APC. Because the packaged code would not be a separately payable procedure, we considered it to be unavailable for use in setting the composite APC median cost. Having identified "single session" claims for the imaging composite APCs, we reassessed the claim to determine if, after removal of all lines for bypass codes, including the "overlap bypass codes," a single unit of a single separately payable code remained on the claim. If so, we attributed the packaged costs on the claim to the single unit of the single remaining separately payable code other than the bypass code to create a "pseudo" single procedure claim. We also identified line-items of overlap bypass codes as a "pseudo" single procedure claim. This allowed us to use more claims data for ratesetting purposes.

As proposed, for this final rule with comment period, we also examined the multiple procedure minor claims to determine whether we could create "pseudo" single procedure claims. Specifically, where the claim contained multiple codes with status indicator

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

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

Lastly, as proposed, for this final rule with comment period, where a multiple procedure minor claim contained multiple codes with status indicator "Q2" ("T-packaged") and status indicator "Q1" ("STVX-packaged"), we selected the status indicator "Q2" HCPCS code ("T-packaged") that had the highest relative weight for CY 2010 and set the units to one on that HCPCS code to reflect our policy of paying only one unit of a code with a status indicator of "Q2." We then packaged all costs for the following into a single cost for the selected ("T-packaged") HCPCS code to create a "pseudo" single procedure claim for that code: Additional units of the status indicator "Q2" HCPCS code with the highest CY 2010 relative weight; other codes with status indicator "Q2;" codes with status indicator "Q1" ("STVX-packaged"); and other packaged HCPCS codes and packaged revenue code costs. We favor status indicator "Q2" over "Q1" HCPCS codes because "Q2" HCPCS codes have higher CY 2010 relative weights. If a status indicator "Q1" HCPCS code had a higher CY 2010 relative weight, it would become the primary code for the simulated single bill process. We changed the status indicator for the selected status indicator "Q2" ("T-packaged") code from a data status indicator of "N" to the status indicator of the APC to which the selected code was assigned and we considered this claim as a major procedure claim.

In public comments received on the CY 2010 OPPS/ASC proposed rule, a public commenter suggested that CMS could use more claims data to develop medians for these conditionally packaged codes if CMS applied the "pseudo" single creation process to the conditionally packaged codes in the multiple major claims that still contained unusable data. We agreed with the commenter and in the CY 2011 proposed rule, we proposed to use the otherwise unusable multiple procedure claims data that remain after the standard pseudo single creation process is applied to them, in order to create more pseudo single procedure claims. We did not receive any public comments on this proposal, and therefore, for the reasons set forth in the proposed rule (75 FR 46201), we followed this practice in creating pseudo single bills for the proposed rule and this final rule with comment period. We do this by treating the conditionally packaged codes that do not meet the criteria for packaging as if they were separately payable major codes and applying the pseudo single process to the claims data to create single procedure claims from them if they meet the criteria for single procedure claims. Conditionally packaged codes are identified using status indicators "Q1" and "Q2," and are described in section XIII.A.1. of this final rule with comment period. Using the February 2010 APC Panel data, we estimated that the impact of adding this proposed additional step to the pseudo single creation process would result in a small increase in the number of claims usable for ratesetting in most cases, but with more significant increases of between 5 to 10 percent of claims for a few codes. For most of the codes affected by adding this proposed additional step to the "pseudo" single creation process, we found no significant changes to the APC medians. Some HCPCS codes do experience some fluctuations, with the impact of additional claims causing their APC median to decrease. We believe that this change is consistent with our goal of using more available data from within the existing set of claims information and results in a more accurate estimation of the APC median cost for conditionally packaged services.

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

c. Completion of Claim Records and Median Cost Calculations

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

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

the I/OCE will package for CY 2011 to ensure consistency.

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

We did not receive any public comments on the proposed packaged revenue codes for CY 2011. Therefore, for the reasons set forth in the proposed rule (75 FR 46201) we are finalizing the proposed packaged revenue codes for CY 2011, without modification, which are identified in Table 3 below. We note that these revenue codes include only revenue codes that were in effect for CY 2009, the year of the claims data on which the CY 2011 OPPS payment rates are based.

TABLE 3—CY 2011 PACKAGED REVENUE CODES

Revenue code	Description
0250	Pharmacy; General Classification.
0251	Pharmacy; Generic Drugs.
0252	Pharmacy; Non-Generic Drugs.
0254	Pharmacy; Drugs Incident to Other Diagnostic Services.
0255	Pharmacy; Drugs Incident to Radiology.
0257	Pharmacy; Non-Prescription.
0258	Pharmacy; IV Solutions.
0259	Pharmacy; Other Pharmacy.
0260	IV Therapy; General Classification.
0261	IV Therapy; Infusion Pump.
0262	IV Therapy; IV Therapy/Pharmacy Svcs.
0263	IV Therapy; IV Therapy/Drug/Supply Delivery.
0264	IV Therapy; IV Therapy/Supplies.
0269	IV Therapy; Other IV Therapy.
0270	Medical/Surgical Supplies and Devices; General Classification.
0271	Medical/Surgical Supplies and Devices; Non-sterile Supply.
0272	Medical/Surgical Supplies and Devices; Sterile Supply.
0275	Medical/Surgical Supplies and Devices; Pacemaker.
0276	Medical/Surgical Supplies and Devices; Intraocular Lens.
0278	Medical/Surgical Supplies and Devices; Other Implants.
0279	Medical/Surgical Supplies and Devices; Other Supplies/Devices.
0280	Oncology; General Classification.
0289	Oncology; Other Oncology.
0343	Nuclear Medicine; Diagnostic Radiopharmaceuticals.
0344	Nuclear Medicine; Therapeutic Radiopharmaceuticals.
0370	Anesthesia; General Classification.
0371	Anesthesia; Anesthesia Incident to Radiology.
0372	Anesthesia; Anesthesia Incident to Other DX Services.
0379	Anesthesia; Other Anesthesia.
0390	Administration, Processing and Storage for Blood and Blood Components; General Classification.
0392	Administration, Processing and Storage for Blood and Blood Components; Processing and Storage.
0399	Administration, Processing and Storage for Blood and Blood Components; Other Blood Handling.
0621	Medical Surgical Supplies—Extension of 027X; Supplies Incident to Radiology.
0622	Medical Surgical Supplies—Extension of 027X; Supplies Incident to Other DX Services.
0623	Medical Supplies—Extension of 027X, Surgical Dressings.
0624	Medical Surgical Supplies—Extension of 027X; FDA Investigational Devices.
0630	Pharmacy—Extension of 025X; Reserved.
0631	Pharmacy—Extension of 025X; Single Source Drug.
0632	Pharmacy—Extension of 025X; Multiple Source Drug.
0633	Pharmacy—Extension of 025X; Restrictive Prescription.
0681	Trauma Response; Level I Trauma.
0682	Trauma Response; Level II Trauma.
0683	Trauma Response; Level III Trauma.

TABLE 3—CY 2011 PACKAGED REVENUE CODES—Continued

Revenue code	Description
0684	Trauma Response; Level IV Trauma.
0689	Trauma Response; Other.
0700	Cast Room; General Classification.
0710	Recovery Room; General Classification.
0720	Labor Room/Delivery; General Classification.
0721	Labor Room/Delivery; Labor.
0732	EKG/ECG (Electrocardiogram); Telemetry.
0762	Specialty services; Observation Hours.
0801	Inpatient Renal Dialysis; Inpatient Hemodialysis.
0802	Inpatient Renal Dialysis; Inpatient Peritoneal Dialysis (Non-CAPD).
0803	Inpatient Renal Dialysis; Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD).
0804	Inpatient Renal Dialysis; Inpatient Continuous Cycling Peritoneal Dialysis (CCPD).
0809	Inpatient Renal Dialysis; Other Inpatient Dialysis.
0810	Acquisition of Body Components; General Classification.
0819	Inpatient Renal Dialysis; Other Donor.
0821	Hemodialysis-Outpatient or Home; Hemodialysis Composite or Other Rate.
0824	Hemodialysis-Outpatient or Home; Maintenance.—100%.
0825	Hemodialysis-Outpatient or Home; Support Services.
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis.
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training.
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation.
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation.

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

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

In accordance with our longstanding practice, as proposed, for this final rule with comment period, we also excluded single and pseudo single procedure claims for which the total cost on the claim was outside 3 standard deviations from the geometric mean of units for each HCPCS code on the bypass list (because, as discussed above, we used claims that contain multiple units of the bypass codes).

After removing claims for hospitals with error CCRs, claims without HCPCS codes, claims for immunizations not covered under the OPPS, and claims for services not paid under the OPPS, approximately 105 million claims were left. Using these 105 million claims, we created approximately 103 million single and "pseudo" single procedure claims, of which we used slightly more than 101 million single bills (after trimming out approximately 792,000 claims as discussed above in this section) in the final CY 2011 median development and ratesetting.

We used these claims to calculate the final CY 2011 median costs for each separately payable HCPCS code and each APC. The comparison of HCPCS code-specific and APC medians determines the applicability of the 2 times rule. Section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (the 2 times rule). We note that, for purposes of identifying significant HCPCS for examination in the 2 times rule, we consider codes that have more than 1,000 single major claims or codes that have both more than 99 single major claims and contribute at least 2 percent of the single major claims used to establish the APC median cost to be significant. Unlisted codes are not used in establishing the percent of claims contributing to the APC, nor are their costs used in the calculation of the APC median. Finally, we reviewed the median costs for the services for which we are paying separately under this final rule with comment period, and we reassigned HCPCS codes to different APCs where it was necessary to ensure clinical and resource homogeneity within the APCs. Section III of this final

rule with comment period includes a discussion of many of the HCPCS code assignment changes that resulted from examination of the median costs and for other reasons. The APC medians were recalculated after we reassigned the affected HCPCS codes. Both the HCPCS code-specific medians and the APC medians were weighted to account for the inclusion of multiple units of the bypass codes in the creation of "pseudo" single procedure claims.

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

We received several general comments on the payment rates CMS proposed in the CY 2011 OPPS/ASC proposed rule:

Comment: Several commenters objected to the volatility of the OPPS rates from year to year. The commenters asserted that the absence of stability in the OPPS rates creates budgeting, planning, and operating problems for hospitals. One commenter suggested that the median costs from claims be adjusted to limit changes from year to year. Some commenters asked that CMS limit any decreases in payment compared to the prior year to no more than a 10-percent decline.

Response: There are a number of factors pertinent to the OPPS that may cause median costs to change from one year to the next. Some of these are a reflection of hospital behavior, and some of them are a reflection of fundamental characteristics of the OPPS as defined in statute. For example, the OPPS payment rates are based on hospital cost report and claims data. However, hospital costs and charges change each year and this results in both changes to the CCRs taken from the most currently available cost reports and also differences in the charges on the claims that are the basis of the calculation of the median costs on which OPPS rates are based. Similarly, hospitals adjust their mix of services from year to year by offering new services and ceasing to furnish services and changing the proportion of the various services they furnish, which have an impact on the CCRs that we derive from their cost reports. CMS cannot stabilize these hospital-driven fundamental inputs to the calculation of OPPS payment rates.

Moreover, there are other essential elements of the OPPS that contribute to the changes in relative weights each year. These include, but are not limited to, reassignments of HCPCS codes to APCs to rectify 2 times rule violations as required by the law, to address the costs of new services, to address differences in hospitals' costs that may result from changes in medical practice, and to respond to public comments. Our efforts to improve payment accuracy may also contribute to payment volatility in the short run, as may be the case when we may eventually be able to use more specific CCRs to estimate the costs of implantable devices, based on the final policy that we adopted to disaggregate the single cost center for medical supplies into two more specific cost centers, as described in the FY 2009 IPPS final rule (73 FR 48458 through 48467). Moreover, for some services, we cannot avoid using small numbers of claims, either because the volume of services is naturally low or because the claims data do not facilitate the calculation of a median cost for a single service. Where there are small numbers of claims that are used in median calculation, there is more volatility in the median cost from one year to the next. Lastly, changes to OPPS payment policy (for example, changes to packaging) also contribute, to some extent, to the fluctuations in the OPPS payment rates for the same services from year to year.

We cannot avoid the naturally occurring volatility in the cost report and claims data that hospitals submit and on which the payment rates are based. Moreover (with limited exceptions), we reassign HCPCS codes to APCs where it is necessary to avoid 2 times rule violations. However, we have made other changes to resolve some of the other potential reasons for instability from year to year. Specifically, we continue to seek ways to use more claims data so that we have fewer APCs for which there are small numbers of single bills used to set the APC median costs. Moreover, we have tried to eliminate APCs with very small numbers of single bills where we could do so. We recognize that changes to payment policies, such as the packaging of payment for ancillary and supportive services and the implementation of composite APCs, may contribute to volatility in payment rates in the short term, but we believe that larger payment packages and bundles should help to stabilize payments in the long term by enabling us to use more claims data and by establishing payments for larger groups of services.

While we recognize the reasoning behind a request to limit reductions in the weights or payment rates of the OPPS, this would not be as simple or beneficial as commenters have implied. Implementing such a policy would require the assumption that payment policy is static from year to year. Based on the data used to develop the OPPS, we know that this is not true. Further, in seeking to mitigate fluctuations in the OPPS, implementing such a system would make payments less reflective of the true service costs. Limiting decreases to payments across all APCs in a budget neutral payment system could unfairly reduce the payments for other services due to the effects of the scaling that is necessary to maintain budget neutrality and would distort the realtivity of payment that is based on the cost of all services.

Comment: Several commenters noted that an analysis of the hospital Medicare cost reports showed a disturbing trend of negative margins and a wide gap between the outpatient margins of major teaching hospitals and those of all other hospitals. The commenters recommended that CMS study whether the hospital outpatient costs of teaching hospitals are higher than the costs of other hospitals for purposes of determining whether there should be a teaching hospital adjustment. The commenters requested that CMS conduct its own analysis and that if that analysis showed a difference due to the unique missions of teaching hospitals, CMS should add a teaching adjustment to the OPPS.

Response: Unlike payment under the IPPS, section 1833(t) of the Act does not require payment for indirect medical education costs to be made under the OPPS. However, section 1833(t)(2)(E) of the Act provides the Secretary with authority to make adjustments under the OPPS in certain circumstances. Specifically, section 1833(t)(2)(E) of the Act states that the Secretary shall establish, in a budget neutral manner "* * * other adjustments as determined to be necessary to ensure equitable payments, such as adjustments for certain classes of hospitals." We have not found such an adjustment to be necessary to ensure equitable payments to teaching hospitals and, therefore, have not developed such an adjustment. Furthermore, in this final rule with comment period, we have developed payment weights that we believe provide appropriate and adequate payment for the complex medical services, such as new technology

services and device-dependent procedures, which we understand are furnished largely by teaching hospitals. We note that teaching hospitals benefit from the recalibration of the APCs in this final rule with comment period and that teaching hospitals benefit from being generally located in areas with relatively high wage indices. With respect to the comment that teaching hospitals experience negative margins and a wide gap in payment between teaching hospitals and other hospitals, we note it is not clear the extent to which a gap between teaching hospitals and other hospitals may be attributable to OPPS or to the costs of medical education for which the law provides payment outside the OPPS. The final CY 2011 impacts by class of hospital are displayed in Table 66 in section XX.B. of this final rule with comment period.

APC Panel Recommendations Regarding Data Development

At the August 2010 APC Panel Meeting, we provided the APC Panel a list of all APCs decreasing by more than 5 percent and increasing by more than 15 percent when comparing the proposed CY 2011 median costs based on data available for the August 2010 APC Panel meeting from CY 2009 claims processed through June 30, 2010, to those based on CY 2010 OPPS/ASC final rule data (CY 2008 claims). The APC Panel reviewed these fluctuations in the APC median costs and recommended that CMS continue to identify increases or decreases in APC median costs of 10 percent or greater and that CMS develop and present explanatory information on APCs with significant changes. The Panel believes that this would help the Data Subcommittee to be able to identify APCs that fluctuate due to coding and APC reassignment changes, and allow them to focus on those that required more investigation. We accept this comment and will furnish the Panel with these data. We note that, in some cases, we may be unable to clearly identify causes for median cost changes, but we will provide explanatory information to the extent possible.

At its August 23–24, 2010 meeting, the APC Panel made a number of recommendations related to the data process. The Panel's recommendations and our responses follow. In instances where we discuss the issue on which the Panel made a recommendation elsewhere in this preamble, we provide the cross-reference to the appropriate section of this final rule with comment period.

Recommendation 1

The Panel recommends that CMS retain the current overall ancillary cost-to-charge ratio (CCR) trim tolerances of 0.0001, 90, and +/− 3 standard deviations from the geometric mean for determining the hospitals whose claims are to be included in ratesetting. The study upon which the Panel based this recommendation is described in section II.A.2.a. of this final rule with comment period.

We are accepting this recommendation.

Recommendation 2

The Panel recommends that CMS investigate and report at a future Panel meeting on the reason for the decline in median cost for APC 0307 (Myocardial Positron Emission Tomography (PET) Imaging) from the calendar year (CY) 2010 OPPS to the proposed CY 2011 OPPS.

This recommendation and APC specific-policies are discussed in section III.D. of this final rule with comment period.

Recommendation 3

The Panel recommends that CMS identify increases or decreases in APC median costs of 10 percent or greater and that CMS develop and present explanatory information on APCs with significant changes.

We are accepting this recommendation, and we discuss APC median cost fluctuations and the recommendation to identify these changes and their potential causes in this section.

Recommendation 4

The Panel commends CMS for providing data analyses requested by the Data Subcommittee.

We appreciate this recommendation.

Recommendation 5

The Panel recommends that Patrick Grusenmeyer, Sc.D., be named chair of the Data Subcommittee.

We are accepting this recommendation.

Recommendation 6

The Panel recommends that the work of the Data Subcommittee continue.

We are accepting this most recent recommendation, and we will continue to work closely with the APC Panel's Data Subcommittee to prepare and review data and analyses relevant to the APC configurations and OPPS payment policies for hospital outpatient items and services.

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

(1) Device-Dependent APCs

Device-dependent APCs are populated by HCPCS codes that usually, but not always, require that a device be implanted or used to perform the procedure. For a full history of how we have calculated payment rates for device-dependent APCs in previous years and a detailed discussion of how we developed the standard device-dependent APC ratesetting methodology, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66739 through 66742). Overviews of the procedure-to-device edits and device-to-procedure edits used in ratesetting for device-dependent APCs are available in the CY 2005 OPPS final rule with comment period (69 FR 65761 through 65763) and the CY 2007 OPPS/ASC final rule with comment period (71 FR 68070 through 68071).

In the CY 2011 OPPS/ASC proposed rule (75 FR 46204 through 46205), we proposed to continue for CY 2011 to use the standard methodology for calculating median costs for device-dependent APCs that was finalized in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60365). This methodology utilizes claims data that generally represent the full cost of the required device. Specifically, we proposed to calculate the median costs for device-dependent APCs for CY 2011 using only the subset of single procedure claims from CY 2009 claims data that pass the procedure-to-device and device-to-procedure edits; do not contain token charges (less than $1.01) for devices; do not contain the "FB" modifier signifying that the device was furnished without cost to the provider, supplier, or practitioner, or where a full credit was received; and do not contain the "FC" modifier signifying that the hospital received partial credit for the device. The "FC" modifier became effective January 1, 2008, and was present for the first time on claims that were used in OPPS ratesetting for CY 2010. The procedure-to-device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code, while the device-to-procedure edits require that a claim that contains one of a specified set of device codes also contain an appropriate procedure code. We stated in the proposed rule that we continue to believe the standard methodology for calculating median costs for device-dependent APCs gives us the most appropriate median costs for device-

dependent APCs in which the hospital incurs the full cost of the device.

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

Comment: Several commenters supported CMS' proposal to continue using the standard methodology for calculating median costs for device-dependent APCs. Some commenters recommended that CMS continue examining and refining the ratesetting methodology for procedures involving devices in order to encourage the continued development and proliferation of new technology. Some commenters also requested the mandatory reporting of all HCPCS device C-codes on hospital claims for services involving devices. The commenters urged CMS to continue educating hospitals on the importance of accurate coding for devices, supplies, and other technologies, and to continue to encourage hospitals to remain vigilant in reporting the costs of performing services involving devices, in order to help ensure that these items are more appropriately reflected in future years' payment rates for outpatient services.

Response: We appreciate the commenters' support of the continued use of the standard device-dependent APC ratesetting methodology.

As we have stated in the past (73 FR 68535 through 68536 and 74 FR 60367), we agree that accurate reporting of device, supply, and technology charges will help to ensure that these items are appropriately accounted for in future years' OPPS payment rates. We encourage stakeholders to carefully review HCPCS code descriptors, as well as any guidance CMS may have provided for specific HCPCS codes. In addition, we have provided further instructions on the billing of medical and surgical supplies in the October 2008 OPPS update (Transmittal 1599, Change Request 6196, dated September 19, 2008) and the April 2009 OPPS update (Transmittal 1702, Change Request 6416, dated March 13, 2009). For HCPCS codes that are paid under the OPPS, providers may also submit inquiries to the AHA Central Office on HCPCS, which serves as a clearinghouse on the proper use of Level I HCPCS codes for hospitals and certain Level II HCPCS codes for hospitals, physicians, and other health professionals. Inquiries must be submitted using the approved form, which may be downloaded from the AHA Web site (*http://www.ahacentraloffice.org*) and either faxed to 312–422–4583 or mailed directly to the AHA Central Office: Central Office on HCPCS, American Hospital Association, One North Franklin, Floor 29, Chicago, IL 60606.

As we have stated in the past (74 FR 60367), we agree with the commenters that we should continue to encourage the development and proliferation of new technology under the OPPS. We have special mechanisms to provide payment for new technologies and services under the OPPS, including new technology APCs and transitional pass-through payments devices. We refer readers to sections III.C. and IV.A., respectively, of this final rule with comment period for more information on these payment methodologies. For all OPPS services, we continue our efforts to use the data from as many claims as possible, through approaches such as use of the bypass list and date splitting of claims as described further in section II.A. of this final rule with comment period, and through methodologies such as increased packaging and composite APCs.

Comment: Several commenters supported the proposed CY 2011 payment rate for the implantation of auditory osseointegrated devices, described by CPT codes 69714 (Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy); 69715 (Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy); 69717 (Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy); and 69718 (Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy), which are assigned to APC 0425. Other commenters also supported the proposed payment rate for APC 0259 (Level VII ENT Procedures), which includes the insertion of a cochlear implant.

Response: We appreciate the commenters' support of the proposed payment rates for procedures involving auditory osseointegrated devices and cochlear implants. We agree that the payment rates for APCs 0259 and 0425, calculated according to the standard device-dependent APC ratesetting methodology for the proposed rule and this final rule with comment period, appropriately reflect hospitals' relative costs for providing these procedures as reported to us in the claims and cost report data.

Comment: One commenter concurred with CMS' determination that APC 0385 (Level I Prosthetic Urological Procedures) and APC 0386 (Level II Prosthetic Urological Procedures) continue to be recognized as device-dependent APCs. The commenter supported CMS' continued application of procedure-to-device edits for procedures assigned to these APCs to ensure the reporting of the appropriate C-code for all device-dependent APCs.

Response: We appreciate the commenter's support of the continued recognition of APCs 0385 and 0386 as device-dependent APCs. We agree that claims processing edits for devices that are integral to the performance of procedures assigned to device-dependent APCs are an important element of the standard device-dependent APC ratesetting methodology.

Comment: Some commenters recommended that CMS create a new APC for three CPT codes currently assigned to APC 0425 (Level II Arthroplasty or Implantation with Prosthesis): CPT code 24363 (Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic

replacement (e.g.., total elbow)); CPT code 25446 (Arthroplasty with prosthetic replacement; distal radius and partial or entire carpus (total wrist)); and CPT code 27446 (Arthroplasty, knee, condyle and plateau; medial OR lateral compartment). One commenter suggested that it would be acceptable also to include CPT code 23470 (Arthroplasty, glenohumeral joint; hemiarthroplasty) in the new APC. According to the commenters, CMS should create a new APC because the proposed payment rate for APC 0425 would result in a significant underpayment for these arthroplasty procedures. The commenters argued that the broad range in the median costs of procedures assigned to APC 0425 violates the 2 times rule.

Response: We do not believe that it is necessary to create a new APC for arthroplasty procedures. We do not agree with the assertion that the current placement of CPT codes 24363, 25446, and 27446 in APC 0425 would result in significant underpayment for these services. Payment based on a measure of central tendency is a principle of any prospective payment system. As we have stated in the past (73 FR 68562), in some individual cases, payment exceeds the average cost, and in other cases, payment is less than the average cost. However, on balance, payment should approximate the relative cost of the average case, recognizing that, as a prospective payment system, the OPPS is a system of averages. As stated in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66639) and the CY 2009 OPPS/ASC final rule with comment period (73 FR 68546), a fundamental characteristic of a prospective payment system is that payment is to be set at an average for the service which, by definition, means that some services are paid more or less than the average.

We also do not agree with the commenters' claim that the current configuration of APC 0425 violates the 2 times rule, which indicates that an APC group cannot be considered comparable with respect to the use of resources if the highest median cost (or mean cost if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the same group. As we describe in section III.B.2. of the proposed rule and this final rule with comment period, we make exceptions to the 2 times rule in unusual cases, such as low-volume items and services, and we only consider significant procedures for purposes of the 2 times assessment. We define significant procedures as those with a single claim frequency of greater than 1,000 or those with a frequency of greater than 99 and that constitute at least 2 percent of single claims in the APC. There are three significant procedures in APC 0425, CPT codes 27446, 23470, and 69714. The CY 2009 hospital outpatient claims used for CY 2011 ratesetting show that the median cost of the lowest cost significant service in the APC, described by CPT code 69714, is approximately $8,212, compared to approximately $9,557 for the highest cost significant service. Based on our claims data, there is no 2 times violation in APC 0425.

Comment: Several commenters have noted that, as discussed earlier in this section, APC 0418 (Insertion of Left Ventricular Pacing Electrode) has demonstrated a significant fluctuation in median costs. The commenters agreed that a significant contributing factor to this fluctuation is a low volume of single bills available for use in ratesetting. The commenters suggested that CMS develop composite APCs for cardiac resynchronization services in order to enable CMS to use more claims data in median cost calculations and to create more appropriate payment rates.

Response: For all OPPS services, we continue our efforts to use the data from as many multiple procedure claims as possible, through approaches such as use of the bypass list and date splitting of claims as described further in section II.A. of this final rule with comment period, and through methodologies such as increased packaging and composite APCs. We refer readers to section II.A.2.e. of this final rule with comment period for a detailed summary of the public comments related to the establishment of a composite payment methodology for procedures involving cardiac resynchronization therapy services and our responses.

After consideration of the public comments we received, we are finalizing our proposed CY 2011 payment policies for device-dependent APCs without modification. The CY 2011 OPPS payment rates for device-dependent APCs are based on their median costs calculated from CY 2009 claims and the most recent cost report data, using only single procedure claims that pass the procedure-to-device and device-to-procedure edits, do not contain token charges for devices, do not have an "FB" modifier signifying that the device was furnished without cost or with full credit, and do not contain an "FC" modifier signifying that the hospital received partial credit for the device. We continue to believe that the median costs calculated from the single claims that meet these criteria represent the most valid estimated relative costs of these services to hospitals when they incur the full cost of the devices required to perform the procedures.

Table 4 below lists the APCs for which we used our standard device-dependent APC ratesetting methodology for CY 2011. We note that we are adding two new device-dependent APCs for CY 2011 to Table 4 APC 0318 (Implantation of Cranial Neurostimulator Pulse Generator and Electrode) and APC 0319 (Endovascular Revascularization of the Lower Extremity). As discussed in sections II.A.2.d.7. and II.A.2.d.9. of this final rule with comment period, we are creating these new device-dependent APCs in order to accommodate revisions to coding in CY 2011 for services that were previously assigned to other device-dependent APCs. We also are deleting APC 0225 from Table 4 below because it is replaced with APC 0318 for CY 2011. We refer readers to Addendum A to this final rule with comment period for the final payment rates for these APCs.

TABLE 4—CY 2011 DEVICE-DEPENDENT APCS

CY 2011 APC	CY 2011 Status indicator	CY 2011 APC Title
0039	S	Level I Implantation of Neurostimulator Generator.
0040	S	Percutaneous Implantation of Neurostimulator Electrodes.
0061	S	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes.
0082	T	Coronary or Non-Coronary Atherectomy.
0083	T	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty.
0084	S	Level I Electrophysiologic Procedures.

TABLE 4—CY 2011 DEVICE-DEPENDENT APCS—Continued

CY 2011 APC	CY 2011 Status indicator	CY 2011 APC Title
0085	T	Level II Electrophysiologic Procedures.
0086	T	Level III Electrophysiologic Procedures.
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes.
0090	T	Insertion/Replacement of Pacemaker Pulse Generator.
0104	T	Transcatheter Placement of Intracoronary Stents.
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes.
0107	T	Insertion of Cardioverter-Defibrillator.
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.
0115	T	Cannula/Access Device Procedures.
0202	T	Level VII Female Reproductive Procedures.
0227	T	Implantation of Drug Infusion Device.
0229	T	Transcatheter Placement of Intravascular Shunts.
0259	T	Level VII ENT Procedures.
0293	T	Level V Anterior Segment Eye Procedures.
0315	S	Level II Implantation of Neurostimulator Generator.
0318	S	Implantation of Cranial Neurostimulator Pulse Generator and Electrode.
0319	T	Endovascular Revascularization of the Lower Extremity.
0384	T	GI Procedures with Stents.
0385	S	Level I Prosthetic Urological Procedures.
0386	S	Level II Prosthetic Urological Procedures.
0418	T	Insertion of Left Ventricular Pacing Electrode.
0425	T	Level II Arthroplasty or Implantation with Prosthesis.
0427	T	Level II Tube or Catheter Changes or Repositioning.
0622	T	Level II Vascular Access Procedures.
0623	T	Level III Vascular Access Procedures.
0648	T	Level IV Breast Surgery.
0652	T	Insertion of Intraperitoneal and Pleural Catheters.
0653	T	Vascular Reconstruction/Fistula Repair with Device.
0654	T	Insertion/Replacement of a Permanent Dual Chamber Pacemaker.
0655	T	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker.
0656	T	Transcatheter Placement of Intracoronary Drug-Eluting Stents.
0674	T	Prostate Cryoablation.
0680	S	Insertion of Patient Activated Event Recorders.

(2) Blood and Blood Products

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46206), we proposed for CY 2011 to continue to establish payment rates for blood and blood products using our blood-specific CCR methodology, which utilizes actual or simulated CCRs from the most recently available hospital cost reports to convert hospital charges for blood and blood products to costs. This methodology has been our standard ratesetting methodology for blood and blood products since CY 2005. It was developed in response to data analysis indicating that there was a significant difference in CCRs for those hospitals with and without blood-specific cost centers, and past public comments indicating that the former OPPS policy of defaulting to the overall hospital CCR for hospitals not reporting a blood-specific cost center often resulted in an underestimation of the true hospital costs for blood and blood products. Specifically, in order to address the differences in CCRs and to better reflect hospitals' costs, we proposed to continue to simulate blood CCRs for each hospital that does not report a blood cost center by calculating the ratio of the blood-specific CCRs to hospitals' overall CCRs for those hospitals that do report costs and charges for blood cost centers. We would then apply this mean ratio to the overall CCRs of hospitals not reporting costs and charges for blood cost centers on their cost reports in order to simulate blood-specific CCRs for those hospitals. We calculated the median costs upon which the proposed CY 2011 payment rates for blood and blood products were based using the actual blood-specific CCR for hospitals that reported costs and charges for a blood cost center and a hospital-specific simulated blood-specific CCR for hospitals that did not report costs and charges for a blood cost center.

We indicated in the CY 2011 OPPS/ASC proposed rule (75 FR 46206) that we continue to believe the hospital-specific, blood-specific CCR methodology better responds to the absence of a blood-specific CCR for a hospital than alternative methodologies, such as defaulting to the overall hospital CCR or applying an average blood-specific CCR across hospitals. Because this methodology takes into account the unique charging and cost accounting structure of each hospital, we believe that it yields more accurate estimated costs for these products. We indicated that we believe that continuing with this methodology in CY 2011 would result in median costs for blood and blood products that appropriately reflect the relative estimated costs of these products for hospitals without blood cost centers and, therefore, for these blood products in general.

We requested public comments in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60373) that addressed whether plasma protein fraction (PPF) products should be recognized as blood and blood products,

designated with status indicator "R," or as nonpass-through drugs and biologicals, designated with status indicator "K." Specifically, we were interested in how PPF is derived and manufactured, and whether the same access and safety concerns that apply to the blood and blood products recognized under the OPPS for payment purposes also apply to PPF. Finally, we were interested in the relationship between albumin and PPF, from clinical, manufacturing, and safety perspectives, and whether there would be a rationale for treating these products similarly for OPPS payment purposes.

Comment: Several commenters asserted that CMS' proposed payments for blood and blood products fail to cover the acquisition and overhead costs incurred by hospitals for procuring, storing, and processing blood and blood products, especially high volume products such as leukocyte reduced red blood cells, described by HCPCS code P9016 (Red blood cells, leukocytes reduced, each unit). Several commenters noted that the most recent preliminary data from the National Blood Collection and Utilization Survey support this assertion, and that the Bureau of Labor and Statistics Producer Price Index (PPI) for blood and blood products increased 1.8 percent in 2010 compared to 2009. Other commenters stated that, as the costs of blood and blood products continue to rise, it is important for CMS to ensure that APC payment rates keep pace with technological advances, safety measures, and donor recruitment challenges. They believed that the 2-year lag inherent in the OPPS ratesetting process does not allow current payment rates to reflect these rising costs.

Response: As we indicated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60372), we continue to believe that using blood-specific CCRs applied to hospital claims data results in payments that appropriately reflect hospitals' relative costs of providing blood and blood products as reported to us by hospitals. We do not believe it is necessary or appropriate to use the PPI for blood and organ banks or survey data as a benchmark for updating the payment rates for blood and blood products from year to year, because it is not our standard process under the OPPS for any item or service to update payment rates by implementing across-the-board, product-specific inflation updates, or updates based on survey data, to the payment rates that were in place the year before. Rather, we annually update payment groups and payment weights using the most recently available hospital claims and cost report data. This process allows us to recalibrate the payment groups and payment weights in response to changes in hospitals' costs from year to year. A fundamental principle of the OPPS is that it is based on relative weights, and as we have stated in the past (73 FR 68541), it is the relativity of the costs to one another, rather than absolute cost, that is important in setting payment rates. To deviate from our standard OPPS ratesetting methodology and update the payment rates for blood and blood products by the PPI or based on survey data would skew this relativity. We also note that the median costs per unit (calculated using the blood-specific CCR methodology) for this final rule with comment period increase for the majority of the most commonly provided blood and blood products (including the highest volume blood and blood product, described by HCPCS code P9016) by 4 percent or greater compared to the CY 2010 median costs.

For all APCs whose payment rates are based upon relative payment weights, we note that the quality and accuracy of reported units and charges significantly influence the median costs that are the basis for our payment rates, especially for low volume items and services. Beyond our standard OPPS trimming methodology (described in section II.A.2. of this final rule with comment period) that we apply to those claims that have passed various types of claims processing edits, it is not our general policy to judge the accuracy of hospital coding and charging for purposes of ratesetting.

Comment: One commenter requested that CMS exclude blood and blood products from the reductions to the increase factor for OPPS services that are mandated by section 3401(i) of the Affordable Care Act.

Response: As discussed in section II.B.1. of this final rule with comment period, for CY 2011, section 3401(i) of the Affordable Care Act mandates a 0.25 percent reduction to the OPPS increase factor. The law does not exclude blood and blood products from this reduction in payment for CY 2011, and we see no basis to implement an exclusion.

Comment: One commenter responded to the request for public comments made in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60373) concerning whether CMS should recognize PPF products as drugs under the OPPS and assign status indicator "K," rather than recognizing them as blood and blood products and assigning them status indicator "R." The same stakeholder also commented on the proposal in the CY 2011 OPPS/ASC proposed rule to maintain the "R" status indicators for these products in CY 2011. In both comment letters, the commenter delineated the relationship between PPF and albumin, indicating that, according to the American Association of Blood Banks (AABB) and the American Hospital Formulary Service, albumin and PPF are derived through very similar processes from human plasma, although PPF is subject to fewer purification steps. According to the commenter, neither albumin nor PPF is given through a filter as is common with blood products, they possess similar pharmacologic properties, contraindications, precautions and adverse reactions; and they are commonly administered interchangeably. The commenter stated that, unlike blood products, PPF and albumin should be stored similarly and not frozen, and although there is potential for transmission of human virus, the risk is rare. The commenter further stated that they do not require type and crossmatching, contain no coagulation factors, and are compatible with whole blood and whole packed red blood cells. Finally, according to the commenter, the AABB indicates in its billing guide for transfusion that albumin and PPF are both blood derivatives. The commenter again recommended that CMS assign HCPCS codes P9043 (Infusion, plasma protein fraction (human), 5%, 50 ml) and P9048 (Infusion, plasma protein fraction (human), 5%, 250 ml) to status indicator "K." The commenter also requested that CMS instruct hospitals to bill for PPF using pharmacy revenue codes, and appropriate injection or infusion CPT codes rather than the CPT code for blood transfusion because the commenter believed this product is a blood derivative.

Response: In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60373), we indicated that, because changing the status indicators for these products as the commenter recommended could have significant payment implications, we are seeking information and input from all interested stakeholders. Specifically, changing the status indicator from "R" to "K" would require us to calculate the payment rates for PPF using mean unit costs from hospital claims data, as we currently do for albumin products, rather than using our standard blood-specific CCR methodology for blood and blood products. We did not receive public comments from other stakeholders within the blood community regarding this potential change in policy, either in response to

the CY 2010 OPPS/ASC final rule with comment period or to the CY 2011 OPPS/ASC proposed rule, and we do not believe we have sufficient clinical information at this time to warrant changing how we have paid for PPF for the last several years. Therefore, we do not believe it is appropriate to change the status indicator assignments for HCPCS codes P9043 and P9048 from status indicator "R" to status indicator "K" for CY 2011.

After consideration of the public comments we received, we are finalizing, without modification, our CY 2011 proposal to calculate median costs upon which the CY 2011 payments rates for blood and blood products are based using our blood-specific CCR methodology, which utilizes actual or simulated CCRs from the most recently available hospital cost reports to convert hospital charges for blood and blood products to costs (the methodology we have utilized since CY 2005). We believe that continuing this methodology in CY 2011 results in median costs for blood and blood products that appropriately reflect the relative estimated costs of these products for hospitals without blood cost centers and, therefore, for these products in general.

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

(3) Single Allergy Tests

In the CY 2011 OPPS/ASC proposed rule (75 FR 46206), we proposed to continue with our methodology of differentiating single allergy tests ("per test") from multiple allergy tests ("per visit") by assigning these services to two different APCs to provide accurate payments for these tests in CY 2011. Multiple allergy tests are currently assigned to APC 0370 (Allergy Tests), with a median cost calculated based on the standard OPPS methodology. We provided billing guidance in CY 2006 in Transmittal 804 (issued on January 3, 2006) specifically clarifying that hospitals should report charges for the CPT codes that describe single allergy tests to reflect charges "per test" rather than "per visit" and should bill the appropriate number of units (as defined in the CPT code descriptor) of these CPT codes to describe all of the tests provided. However, as noted in the proposed rule, our CY 2009 claims data available for the proposed rule for APC 0381 did not reflect improved and more consistent hospital billing practices of "per test" for single allergy tests. The median cost of APC 0381, calculated for the proposed rule according to the standard single claims OPPS methodology, was approximately $52, significantly higher than the CY 2010 median cost of APC 0381 of approximately $29 calculated according to the "per unit" methodology, and greater than we would expect for these procedures that are to be reported "per test" with the appropriate number of units. Some claims for single allergy tests still appear to provide charges that represent a "per visit" charge, rather than a "per test" charge. Therefore, consistent with our payment policy for single allergy tests since CY 2006, we calculated a proposed "per unit" median cost for APC 0381, based upon 595 claims containing multiple units or multiple occurrences of a single CPT code. The proposed CY 2011 median cost for APC 0381 using the "per unit" methodology was approximately $29. For a full discussion of this methodology, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66737).

We did not receive any public comments on our CY 2011 proposal for determining payment of single allergy tests. We are finalizing our CY 2011 proposal, without modification, to calculate a "per unit" median cost for APC 0381 as described above in this section. The final CY 2011 median cost of APC 0381 is approximately $33.

(4) Hyperbaric Oxygen Therapy (APC 0659)

Since the implementation of OPPS in August 2000, the OPPS has recognized HCPCS code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval) for hyperbaric oxygen therapy (HBOT) provided in the hospital outpatient setting. In the CY 2005 final rule with comment period (69 FR 65758 through 65759), we finalized a "per unit" median cost calculation for APC 0659 (Hyperbaric Oxygen) using only claims with multiple units or multiple occurrences of HCPCS code C1300 because delivery of a typical HBOT service requires more than 30 minutes. We observed that claims with only a single occurrence of the code were anomalies, either because they reflected terminated sessions or because they were incorrectly coded with a single unit. In the same rule, we also established that HBOT would not generally be furnished with additional services that might be packaged under the standard OPPS APC median cost methodology. This enabled us to use claims with multiple units or multiple occurrences. Finally, we also used each hospital's overall CCR to estimate costs for HCPCS code C1300 from billed charges rather than the CCR for the respiratory therapy or other departmental cost centers. The public comments on the CY 2005 OPPS proposed rule effectively demonstrated that hospitals report the costs and charges for HBOT in a wide variety of cost centers. Since CY 2005, we have used this methodology to estimate the median cost for HBOT. The median costs of HBOT using this methodology have been relatively stable for the last 5 years.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46206), for CY 2011, we proposed to continue using the same methodology to estimate a "per unit" median cost for HCPCS code C1300. This methodology resulted in a proposed APC median cost of approximately $109 using 328,960 claims with multiple units or multiple occurrences for HCPCS code C1300 for CY 2011.

We did not receive any public comments on our proposal to continue to use our established ratesetting methodology for calculating the median cost of APC 0659 for payment of HBOT for CY 2011. We are finalizing our CY 2011 proposal, without modification, to continue to use our established ratesetting methodology for calculating the median cost of APC 0659 for payment of HBOT, with a final CY 2011 median cost of approximately $150.

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

In the November 1, 2002 final rule with comment period (67 FR 66798), we discussed the creation of the new HCPCS modifier –CA to address situations where a procedure on the OPPS inpatient list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, and the patient dies before being admitted as an inpatient. HCPCS modifier –CA is defined as a procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission. In Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of this modifier. For a complete description of the history of the policy and the development of the

payment methodology for these services, we refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68157 through 68158).

In the CY 2011 OPPS/ASC proposed rule (75 FR 46207), for CY 2011, we proposed to continue to use our established ratesetting methodology for calculating the median cost of APC 0375 (Ancillary Outpatient Services When Patient Expires) and to continue to make one payment under APC 0375 for the services that meet the specific conditions for using HCPCS modifier –CA. We proposed to calculate the relative payment weight for APC 0375 by using all claims reporting a status indicator "C" (inpatient procedures) appended with HCPCS modifier –CA, using estimated costs from claims data for line-items with a HCPCS code assigned to status indicators "G," "H," "K," "N," "Q1," "Q2," "Q3," "R," "S," "T," "U," "V," and "X" and charges for packaged revenue codes without a HCPCS code. (We refer readers to section XIII.A.1. of this final rule with comment period for a complete listing of status indicators). We continue to believe that this methodology results in the most appropriate aggregate median cost for the ancillary services provided in these unusual clinical situations.

As discussed in the CY 2011 OPPS/ASC proposed rule (75 FR 46207), we believe that hospitals are reporting the HCPCS modifier –CA according to the policy initially established in CY 2003. We note that the claims frequency for APC 0375 has been relatively stable over the past few years. Although the median cost for APC 0375 has increased, the median in the CY 2009 OPPS claims data used for development of proposed rates for CY 2011 was only slightly higher than that for CY 2010. Variation in the median cost for APC 0375 is expected because of the small number of claims and because the specific cases are grouped by the presence of the HCPCS modifier –CA appended to an inpatient procedure and not according to the standard APC criteria of clinical and resource homogeneity. Cost variation for APC 0375 from year to year is anticipated and acceptable as long as hospitals continue judicious reporting of the HCPCS modifier –CA. Table 5 of the proposed rule (75 FR 46207) showed the number of claims and the proposed median costs for APC 0375 for CYs 2007, 2008, 2009, and 2010. For CY 2011, we proposed a median cost of approximately $6,566 for APC 0375 based on 117 claims.

We did not receive any public comments regarding this proposal. Therefore, for the reasons explained in the CY 2011 OPPS/ASC proposed rule (75 FR 46207), we are finalizing our CY 2011 proposal, without modification, to continue to use our established ratesetting methodology for calculating the median cost of APC 0375, which has a final CY 2011 APC median cost of approximately $6,304. Table 5 below shows the number of claims and the final median costs for APC 0375 for CYs 2007, 2008, 2009, 2010, and 2011.

TABLE 5—CLAIMS FOR ANCILLARY OUTPATIENT SERVICES WHEN PATIENT EXPIRES (–CA MODIFIER) FOR CYS 2007 THROUGH 2011

Prospective payment year	Number of claims	APC median cost
CY 2007	260	$3,549
CY 2008	183	4,945
CY 2009	168	5,545
CY 2010	182	5,911
CY 2011	168	6,304

(6) Pulmonary Rehabilitation (APC 0102)

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46207 through 46208), for CY 2011, we proposed to continue to require hospitals to report PR services provided under the comprehensive PR benefit provided by section 1861(fff) of the Act using HCPCS code G0424. We also proposed to continue to use the methodology described in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60567 through 60570) to calculate the median cost on which the proposed payment rate for CY 2011 is based. Specifically, we proposed to continue to assign HCPCS code G0424 to APC 0102 and to calculate a median "per session" cost simulated from historical hospital claims data for similar pulmonary therapy services for the CY 2011 OPPS.

To simulate the proposed "per session" median cost of HCPCS code G0424 from claims data for existing services, we used only hospital claims that contained at least one unit of HCPCS code G0239 (Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)), the group code that is without limitation on time duration, and one unit of HCPCS code G0237 (Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)) or G0238 (Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)), the individual, face-to-face codes that report 15 minutes of service on the same date of service. We continue to believe that patients in a PR program would typically receive individual and group services during each session of approximately 1 hour in duration. This proposal is consistent with public comments received on the CY 2010 OPPS/ASC proposed rule that were addressed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60569). The commenters to the CY 2010 OPPS/ASC proposed rule suggested that PR is often provided in group sessions in the HOPD, although patients commonly require additional one-on-one care in order to fully participate in the program. We note that our use of "per session" claims that report one unit of HCPCS code G0237 or G0238 and one unit of HCPCS code G0239 in this simulation methodology is also consistent with our overall finding that approximately 2.4 service units of the HCPCS G-codes are furnished per day on a single date of service, usually consisting of both individual and group services, for patients receiving pulmonary therapy services in the HOPD based upon CY 2008 claims used for CY 2010 OPPS final rule ratesetting. We continue to believe that the typical session of PR is 1 hour based on public comments that indicated a session of PR is typically 1 hour and on our findings that the most commonly reported HCPCS code for pulmonary treatment is HCPCS code G0239, which has no time definition for this group service.

In the calculation of the CY 2011 proposed median cost for APC 0102, we included all costs of the related tests and assessment services, including CPT codes 94620 (Pulmonary stress testing, simple (*e.g.* 6-minute walk test,

prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)), 94664 (Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device), and 94667 (Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation) and all the costs of all CPT codes for established patient clinic visits on the same date of service as the HCPCS codes in the claims we used to simulate the median cost for HCPCS code G0424, which is the only HCPCS code in APC 0102. After identifying these "per session" claims, which we believe represent 1 hour of care, we summed the costs and calculated the median cost for the set of selected claims. In light of the cost and clinical similarities of PR and the existing services described by HCPCS codes G0237, G0238, and G0239 and the CPT codes for related assessments and tests, and the significant number of "per session" hospital claims we found, we indicated in the CY 2011 OPPS/ASC proposed rule that we were confident that the proposed simulated median cost for HCPCS code G0424 and APC 0102 of approximately $68 was a valid estimate of the expected hospital cost of a PR session. We noted that this proposed median cost was higher than the CY 2010 final rule median cost for HCPCS code G0424 and APC 0102 of approximately $50 on which the CY 2010 payment is based.

Comment: Several commenters approved the increase in payment for PR services to $68 per hour for CY 2011, stating that the rate better represents actual costs. One commenter noted a CPT proposal to change the reference code for the pulmonary rehabilitation portion of lung volume reduction surgery from CPT code 93797 (Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session) to CPT code 93798 (Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session). The commenter stated that CPT code 93798 is a more appropriate comparison for HCPCS code G0424. In addition, the commenters noted that CPT code 94620 (Pulmonary stress testing; simple (*e.g.* 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)) is paid at a rate of $65 in the office setting when performed alone, and when performed with pulmonary rehabilitation, they are bundled into APC 0102 with a proposed payment rate of $68 in the hospital outpatient setting and with a proposed payment rate of $28.58 when the service is provided in the office setting.

Response: We appreciate the provided information on the change to the reference code for the pulmonary rehabilitation portion of lung volume reduction surgery. We believe the commenter relayed this information to support the proposed increase in payment for HCPCS code G0424 because CPT code 97398 contains continuous ECG monitoring and CPT code 97397 does not. While we observe a minimal difference in estimated cost for CPT codes 93797 and 93798 in the CY 2009 claims data that we used to model payments in this final rule with comment period, we do not believe this influenced the observed increase between the CY 2010 median cost of $50 and the proposed CY 2011 median cost of $68. The proposed CY 2011 median cost for HCPCS code G0424 was based on costs estimated from hospital charges on CY 2009 claims for HCPCS codes G0237, G0238, and G0239 and supporting services CPT codes 94620, 94664, and 94667 and all costs of all CPT codes for established patient clinic visits reported on the same date. We believe the observed increase in the median cost for HCPCS code G0424 may be attributable to changes in hospital charges for these codes or to a change in the mix of hospitals reporting these services in the CY 2009 claims data.

With regard to the comment about CPT code 94620, we believe the commenter intended to point out that the median cost for HCPCS code G0424 does not adequately reflect the cost associated with the 6 minute walk test. In our analysis for creating a simulated median cost for G0424 in the CY 2010 final rule with comment period, we observed that CPT code 94620 appeared on the same claim as HCPCS codes G0237, G0238, and G0239 in approximately 3 percent of the cases, indicating that this service is rarely performed as part of a typical pulmonary rehabilitation session. The proposed median cost of $68 for HCPCS code G0424 reflects the packaged cost of CPT code 94620 and related services to the extent that hospitals report this service in conjunction with pulmonary rehabilitation.

After consideration of the public comments we received, we are finalizing our proposal, without modification, to establish a median cost for APC 0102 by using claims with one unit of HCPCS code G0239, and one unit of HCPCS code G0237 or G0238, and including all costs of the related tests and assessment services (CPT codes 94620, 94664, and 94667 and all the costs of all CPT codes for established patient clinic visits reported on the same date), which results in a final CY 2011 median cost for HCPCS code G0424 of approximately $62.

(7) Endovascular Revascularization of the Lower Extremity (APCs 0083, 0229, and 0319)

For CY 2011, the AMA's CPT Editorial Panel created 16 new CPT codes in the Endovascular Revascularization section of the 2011 CPT Code Book to describe endovascular revascularization procedures of the lower extremity performed for occlusive disease. Table 6 lists the 16 new CPT codes that will be effective January 1, 2011.

TABLE 6—NEW ENDOVASCULAR REVASCULARIZATION CPT PROCEDURE CODES EFFECTIVE JANUARY 1, 2011

CPT Code	Long descriptor
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty.
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed.
37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure).
37223	Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed.
37224	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty.
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed.

TABLE 6—NEW ENDOVASCULAR REVASCULARIZATION CPT PROCEDURE CODES EFFECTIVE JANUARY 1, 2011—Continued

CPT Code	Long descriptor
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed.
37227	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed.
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty.
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed.
37230	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed.
37231	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed.
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure).
37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed.
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed.
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed.

Our standard process for dealing with new CPT codes is to assign the code to the APC that we believe contains services that are comparable with respect to clinical characteristics and resources required to furnish the service. The new CPT code is given a comment indicator of "NI" to identify it as a new interim APC assignment for the new year and the APC assignment for the new codes is then open to public comment. In some, but not all, cases, we are able to use the existing data from established codes to simulate an estimated median cost for the new code to guide us in the assignment of the new code to an APC. In the case of the new endovascular revascularization codes, we were able to use the existing CY 2009 claims and most current cost report data to create simulated median costs for 12 of the 16 new separately payable codes.

Specifically, to estimate the hospital costs associated with the 16 new endovascular revascularization CPT codes based on their CY 2011 descriptors, we used claims data from hospital outpatient claims submitted in CY 2009 and the most recent cost report information submitted by the hospitals that submitted claims for the services as they were reported in CY 2009. We note that all of the services that were previously reported to describe endovascular revascularization of the lower extremity for occlusive disease were assigned to three APCs in CY 2009. These included APCs 0082 (Coronary or Non-Coronary Atherectomy), 0083 (Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty), and 0229 (Transcatheter Placement of Intravascular Shunts).

Because the endovascular revascularization CPT codes are new for CY 2011, we used our CY 2009 single and "pseudo" single claims data to simulate the new CY 2011 CPT code definitions. As shown in Table 7 below, many of the new endovascular revascularization CPT codes were previously reported using a combination of CY 2009 CPT codes. In order to simulate median costs, we selected claims that we believe meet the definition for each of the new endovascular revascularization CPT codes. Table 7 shows the criteria we applied to select a claim to be used in the calculation of the median cost for the new codes (shown in column A). We developed these criteria based on our clinicians' understanding of services that were reported by CY 2009 CPT codes that, in various combinations, reflect the services provided that are described by the new CPT codes for CY 2011. For example, in CY 2009, the procedure described by new CY 2011 CPT code 37222 (Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)) would have been reported using the following combination of procedures: (1) The transluminal balloon angioplasty of the iliac would have been reported using CPT code 35454 (Transluminal balloon angioplasty, open; iliac) or 35473 (Transluminal balloon angioplasty, percutaneous; iliac); (2) the catheter placement would have been reported using CPT code 36248 (Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)); and (3) the radiological supervision and interpretation of the transluminal balloon angioplasty would have been reported using CPT code 75962 (Transluminal balloon angioplasty, peripheral artery, other than cervical carotid, renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation) and/or 75964 (Transluminal balloon angioplasty, each additional peripheral artery other than cervical carotid, renal or other visceral artery, iliac and lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)). In columns B, C, D, and E of Table 7, for each new CY 2011 CPT code listed under column A, we identified the CY 2009 CPT codes that we believed corresponded to each new code for which we had CY 2009 claims data and that we required or permitted to be reported on the same line-item date of service for a particular claim to be used for calculating the median costs for the new codes. Specifically, we

required that at least one unit of one of the separately payable codes in column B must be on the claim (we permitted any number of units of these codes to be on the claim). Where there are codes listed in column C, we also required that at least one unit of one and only one of the codes that appears under column C must be on the claim (we permitted any number of units of the code to be on the claim). Where there are codes in column D, we required at least one unit of each of the codes in column D (we permitted any number of units of these codes to be on the claim). In addition, in column E, we identified several codes that were paid separately in CY 2009 but which we decided should be packaged into the new endovascular revascularization CPT codes if they appeared on the claim with the other codes in columns B through D.

For example, in determining the CPT median cost for new CPT code 37221, we used only those claims that contained one unit of one and only one of the CPT codes listed under column B, specifically CPT code 37205 or 37207, and at least one unit (while allowing multiple units) of one and only one of the CPT codes that appear under column C, specifically CPT codes 36000, 36245, or 36246. We allowed any number of units for the code in column D, and packaged the costs for the codes in column E (CPT codes 35454 and 35473) if they appeared on the claim. We applied this same methodology to select claims that we believe reflected the services defined in each new CPT code. In addition, we excluded claims that met these criteria if the claim contained a service to which a status indicator of "S," "T," "V," or "X" was assigned, if such code did not meet the criteria for the new code. By doing this, we simulated a single procedure bill for the new code. In addition, we applied the standard packaging, trimming, and wage standardization that we apply in the median calculation process. We used approximately 19,283 claims that met the code specific criteria to calculate CPT level medians and the median cost for these new codes. Table 7 below displays the combinations of CY 2009 code data that we used to select the claims we used to create simulated median costs for the new codes (columns A through E), and the frequency of claims that met the criteria (column F) we calculated for each new code using the CY 2009 data for the previously existing CPT codes for these services. We note that we did not identify any claims that met the criteria for new CPT codes 37222, 37223, 37234 and 37235, in part due to the requirement that there must be no major separately paid procedures on the claim other than those we identified for the new code.

TABLE 7—SIMULATED CY 2009 CODE COMBINATIONS AND FREQUENCIES FOR THE NEW CY 2011 ENDOVASCULAR REVASCULARIZATION CPT CODES

CY 2011 CPT Code	First Required CY 2009 CPT Code (At least one unit (and allow any number of units) of one and only one code must appear on the claim)	Second Required CY 2009 CPT Code (At least one unit (and allow any number of units) of one and only one code must appear on the claim)	Third Required CY 2009 CPT Code (At least one unit of each code is required and any number of units of all codes permitted)	Fourth Required CY 2009 CPT Code (Packaged if appeared on claim)	Frequencies
Column A	Column B	Column C	Column D	Column E	Column F
37220	35454	36000	75962	.....	508
	35473	36245	.....	.....	.....
	.....	34246	.....	.....	.....
37221	37205	36000	75960	35454	4,758
	37207	36245	.....	35473	.....
	.....	36246	.....	.....	.....
37222	35454	36248	75962	.....	0
	35473	.....	75964	.....	.....
37223	37206	36248	75960	35454	0
	37208	.....	.....	35473	.....
37224	35456	.....	75962	.....	3,653
	35474	.....	36247	.....	.....
37225	35483	.....	75992	35456	1,974
	35493	.....	36247	35474	.....
37226	37205	.....	75960	35456	2,927
	37207	.....	36247	35474	.....
37227	37205	35483	75960	35456	647
	37207	35493	75992	35474	.....
	.....	.....	36247	.....	.....
37228	35459	.....	75962	.....	1,431
	35470	.....	36247	.....	.....
37229	35485	.....	75992	35459	780
	35495	.....	36247	35470	.....
37230	37205	.....	75960	35459	2,542
	37207	.....	36247	35470	.....
37231	37205	35485	75960	35459	53
	37207	35495	75992	35470	.....
	.....	.....	36247	.....	.....
37232	35459	.....	75964	.....	7
	35470	.....	36248	.....	.....
37233	35485	.....	75993	35459	3
	35495	.....	36248	35470	.....
37234	37206	.....	75960	35459	0
	37208	.....	36248	35470	.....
37235	37206	35485	36247	35459	0
	37208	35495	36248	35470	.....
	.....	.....	75960	.....	.....
	.....	.....	75993	.....	.....

After determining the simulated median costs for the procedures, we assigned each CPT code to appropriate APCs based on their clinical homogeneity and resource use. Of the 16 new codes, we assigned nine CPT codes to APC 0083, five to APC 0229, and created a new APC for two CPT codes. Specifically, we assigned CPT codes 37220, 37221, 37222, 37223, 37224, 37228, 37232, 37234, and 37235 to APC 0083, which has a final CY 2011 APC median cost of approximately $3,740. In addition, we assigned CPT codes 37225, 37226, 37229, 37230, and 37233 to APC 0229, which has a final CY 2011 APC median cost of approximately $7,940. Because the resource costs associated with CPT codes 37227 and 37231 are not similar to the costs of procedures in the existing APCs, we established a new APC, specifically APC 0319 (Endovascular Revascularization of the Lower Extremity), which has a final CY 2011 APC median cost of approximately $13,751 to appropriately pay for these services.

The new CY 2011 endovascular revascularization CPT codes and their final CY 2011 APC assignments and APC median costs are displayed in Table 8 below. We note that because these codes are new for CY 2011, they will be identified with comment indicator "NI" in Addendum B of this final rule to identify them as subject to public comment. We specifically request public comment on our methodology for simulating the median costs for these new CY 2011 CPT codes, in addition to public comments on the payment rates themselves.

TABLE 8—FINAL CY 2011 APC ASSIGNMENTS AND MEDIAN COSTS FOR THE ENDOVASCULAR REVASCULARIZATION CPT CODES

CY 2011 CPT Code	CY 2011 Long descriptor	Final CY 2011 APC	Final CY 2011 CPT median cost
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty.	0083	$5,080
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed.	0083	6,710
37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure).	0083	N/A
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed.	0083	N/A
37224	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty.	0083	5,247
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed.	0229	9,023
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed.	0229	9,600
37227	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed.	0319	13,754
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty.	0083	5,563
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed.	0229	9,231
37230	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) , includes angioplasty within the same vessel, when performed.	0229	7,868
37231	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed.	0319	13,604
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure).	0083	9,412
37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed.	0229	10,183
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed.	0083	N/A
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy (List separately in addition to code for primary procedure), includes angioplasty within the same vessel, when performed.	0083	N/A

(8) Non-Congenital Cardiac Catheterization (APC 0080)

For CY 2011, the AMA CPT Editorial Panel deleted 19 non-congenital cardiac catheterization-related CPT codes and replaced them with 20 new CPT codes in the Cardiac Catheterization and Injection-Related section of the 2011 CPT Code Book to describe more precisely the specific services provided during cardiac catheterization procedures. In particular, the CPT Editorial Panel deleted 19 non-congenital cardiac catheterization-related CPT codes from the 93500 series and created 14 new CPT codes in the 93400 series and 6 in the 93500 series. Table 9 below lists the specific CPT codes that will be deleted December 31, 2010, and Table 10 lists the new CPT codes that will be effective January 1, 2011.

TABLE 9—NON-CONGENITAL CARDIAC CATHETERIZATION-RELATED CPT PROCEDURE CODES THAT WILL BE DELETED DECEMBER 31, 2010

CY 2010 CPT Code	Long descriptor
93501	Right heart catheterization
93508	Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization
93510	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous
93511	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; by cutdown
93514	Left heart catheterization by left ventricular puncture
93524	Combined transseptal and retrograde left heart catheterization
93526	Combined right heart catheterization and retrograde left heart catheterization
93527	Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)
93528	Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)
93529	Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)
93539	Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (e.g., internal mammary), whether native or used for bypass
93540	Injection procedure during cardiac catheterization; for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries
93541	Injection procedure during cardiac catheterization; for pulmonary angiography
93542	Injection procedure during cardiac catheterization; for selective right ventricular or right atrial angiography
93543	Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography
93544	Injection procedure during cardiac catheterization; for aortography
93545	Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)
93555	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography
93556	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)

TABLE 10—NEW CARDIAC CATHETERIZATION-RELATED CPT PROCEDURE CODES EFFECTIVE JANUARY 1, 2011

CY 2011 CPT Code	Long descriptor
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) including intraprocedural injection(s) for bypass graft angiography
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography

TABLE 10—NEW CARDIAC CATHETERIZATION-RELATED CPT PROCEDURE CODES EFFECTIVE JANUARY 1, 2011—Continued

CY 2011 CPT Code	Long descriptor
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)
93463	Pharmacologic agent administration (e.g., inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed
93464	Physiologic exercise study (e.g., bicycle or arm ergometry including assessing hemodynamic measurements before and after) (List separately in addition to code for primary procedure)
93563	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)
93564	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (e.g., aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (e.g., internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)
93565	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)
93566	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)
93567	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)
93568	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)

Of the 19 deleted non-congenital cardiac catheterization-related CPT codes, 9 of the CPT codes describe either a left heart catheterization, right heart catheterization, or a combined left and right heart catheterization, 7 CPT codes describe injection procedures during cardiac catheterization, 2 CPT codes describe imaging supervision during cardiac catheterization, and only 1 CPT code describes a catheter placement. Of the 19 deleted non-congenital cardiac catheterization-related CPT codes, 10 CPT codes have been separately payable under the hospital OPPS, while the other 9 CPT codes that describe injection procedures and imaging supervision during cardiac catheterization have been packaged. Specifically, the 10 non-congenital cardiac catheterization-related CPT codes that have been separately payable under the hospital OPPS include CPT codes 93501, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, and 93529. Alternatively, the nine non-congenital cardiac catheterization-related CPT codes that have been packaged under the hospital OPPS include CPT codes 93539, 93540, 93541, 93542, 93543, 93544, 93545, 93555, and 93556.

Of the 20 new CPT codes, 4 CPT codes describe either a left heart catheterization, right heart catheterization, or a combined left and right heart catheterization, 8 CPT codes describe a catheter placement, 1 CPT code describes a pharmacologic agent administration, 1 CPT code describes a physiologic exercise study, and 6 CPT codes describe a combination of injection procedures with imaging supervision during cardiac catheterization. With the exception of one CPT code (CPT code 93451), many of the new CY 2011 CPT codes are described by multiple CY 2010 CPT codes.

Our standard process for assigning new CPT codes to APCs is to assign the code to the APC that we believe contains services that are comparable with respect to clinical characteristics and resources required to furnish the service. The new CPT code is given a comment indicator of "NI" to identify it as a new interim APC assignment for the new first year and the APC assignment for the new codes is then open to public comment. In some, but not all, cases, we are able to use the existing data from established codes to simulate an estimated median cost for the new code to guide us in the assignment of the new code to an APC. In the case of the new cardiac catheterization codes, we were able to use the existing CY 2009 claims data and the most recent cost report data to create simulated medians for the new separately payable CPT codes.

Specifically, to estimate the hospital costs associated with the 20 new non-congenital cardiac catheterization-related CPT codes based on their CY 2011 descriptors, we used claims and cost report data from CY 2009. We note that all of the services that describe cardiac catheterization procedures, which include both congenital and non-congenital cardiac catheterization, are assigned to APC 0080 (Diagnostic Cardiac Catheterization) in CY 2010. Because of the substantive coding changes associated with the new non-congenital cardiac catheterization-related CPT codes for CY 2011, we used our CY 2009 single and "pseudo" single claims data to simulate the new CY 2011 CPT code definitions. As shown in Table 11 and as stated above, many of the new CPT codes were previously reported using multiple CY 2009 CPT codes. In order to simulate median costs, we selected claims that we believe meet the definition for each of the new CY 2011 non-congenital cardiac catheterization codes. Table 11 shows the criteria we applied to select a claim to be used in the calculation of the median cost for the new codes (shown in column A). We developed these

criteria based on our clinicians' understanding of services that were reported by CY 2009 CPT codes that, in various combinations, reflect the services provided that are described in the new CPT codes. For example, in CY 2009, the procedure described by new CY 2011 CPT code 93454 (Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation) would have been reported using the following combination of procedures: (1) The catheter placement would have been reported using CPT code 93508 (Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization); and (2) the injection procedure would have been reported using CPT code 93545 (Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand); and CPT code 93556 (Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)). In columns B, C, and D of Table 11, for each new CY 2011 CPT code listed under column A, we identified both the CPT codes that corresponded to each new code for which we had CY 2009 claims data and that we required or permitted to be reported on the same line-item date of service for a particular claim to be used for median setting for the new codes. Specifically, we required that only one unit of one and only one of the separately payable codes in column B must be present on the claim. We also required that at least one unit of each code that appears under column C must be present on the claim, and we permitted any number of these codes and any number of units of these codes to be present on the claim. Where there are codes in column D, we required at least one unit of one of at least one of the codes in column D must be on the claim, but we permitted any number of units of any of the codes shown in column D for the new code.

For example, in determining the CPT median cost for new CPT code 93452, we used only those claims that contained one unit of one and only one of the CPT codes listed under column B, specifically, CPT codes 93510, 93511, 93514, or 93524, and at least one unit (while allowing multiple units) of each of the CPT codes that appear under column C, specifically, CPT codes 93543 and 93555. Because, in the case of CPT code 93452, there are no third level codes in the definition of CPT code 93452, no other code criteria applied and column D is left blank. In the case of new CPT codes 93459 and 93461, there are third level criteria in column D, and for those two CPT codes, we required that the claim contain at least one unit of one code in column D, and we allowed any number of units for any code in column D. We applied this same methodology to select claims that we believe reflected the services defined in each new CPT code. We used approximately 175,000 claims for the new non-congenital catheterization-related CPT codes, together with the single and pseudo single procedure claims for the remaining congenital catheterization-related CPT codes in APC 0080, to calculate CPT level median costs and the median cost for APC 0080 of approximately $2,698. Table 11 displays the combinations of CY 2009 CPT code data that we used to select the claims we used to create simulated median costs for the new CPT codes (columns A through D), the frequency of claims that met the criteria (column E), and the median costs we calculated for each new CPT code using the CY 2009 claims data for the previously existing CPT codes describing these services (column F). We note that because the CPT codes listed in column A are new for CY 2011, they will be identified with comment indicator "NI" in Addendum B of this final rule with comment period to identify them as subject to public comment. We are specifically requesting public comment on our methodology for simulating the median costs for these new CY 2011 CPT codes, in addition to public comments on the payment rates themselves.

TABLE 11—CY 2009 CODE COMBINATIONS, FREQUENCIES, AND SIMULATED MEDIAN COSTS FOR NEW CY 2011 CARDIAC CATHETERIZATION–RELATED CODES

CY 2011 CPT Code	First Required CY 2009 CPT Code (Only one unit of one and only one code must appear on the claim)	Second Required CY 2009 CPT Code (At least one unit of each code; any number of codes or units of a code may be on the claim)	Third Required CY 2009 CPT Code (Any number of units of at least one code; any number of units of all codes permitted)	Frequencies	CPT Medians
Column A	Column B	Column C	Column D	Column E	Column F
93451	93501	.....	.....	3,552	1,493
93452	93510	93543	.....	1,055	2,876
	93511	93555	.....	.....	.....
	93514	.....	.....	.....	.....
	93524	.....	.....	.....	.....
93453	93526	93543	.....	225	3,182
	93527	93555	.....	.....	.....
	93528	.....	.....	.....	.....
	93529	.....	.....	.....	.....
93454	93508	93545	.....	7,852	2,497
		93556	.....	.....	.....
93455	93508	93545	.....	1,683	2,673
		93556	.....	.....	.....
		93539	.....	.....	.....
		93540	.....	.....	.....
93456	93508	93501	.....	914	2,502
		93545	.....	.....	.....
		93556	.....	.....	.....
93457	93508	93545	.....	159	3,923
		93556	.....	.....	.....
		93539	.....	.....	.....
		93540	.....	.....	.....
		93501	.....	.....	.....
93458	93510	93545	.....	112,395	2,663
	93511	93555	.....	.....	.....
	93514	93556	.....	.....	.....
	93524	93543	.....	.....	.....
93459	93510	93545	93539	23,352	2,911
	93511	93555	93540	.....	.....
	93514	93556	.....	.....	.....
	93524	93543	.....	.....	.....
93460	93526	93545	.....	20,697	3,135
	93527	93556	.....	.....	.....
	93528	93543	.....	.....	.....
	93529	93555	.....	.....	.....
93461	93526	93545	93539	3,445	3,382
	93527	93556	93540	.....	.....
	93528	93543	.....	.....	.....
	93529	93555	.....	.....	.....

(9) Cranial Neurostimulator and Electrodes (APC 0318)

For CY 2011, the AMA CPT Editorial Panel created a new CPT code 64568 (Incision for implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator) and indicates that it describes the services formerly included in the combinations of (1) CPT code 64573 (Incision for implantation of neurostimulator electrodes; cranial nerve) and CPT code 61885 (Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array); or (2) CPT code 64573 and CPT code 61886 (Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays). Our standard process for assigning new CPT codes to APCs is to assign the code to the APC that we believe contains services that are comparable with respect to clinical characteristics and resources required to furnish the service. The new CPT code is given a comment indicator of "NI" to identify it as a new interim APC assignment for the new first year and the APC assignment for the new code is then open to public comment. In some, but not all, cases, we are able to use the existing data from established codes to simulate an estimated median cost for the new code to guide us in the assignment of the new code to an APC. In the case of the new neurostimulator electrode and pulse generator implantation CPT code, we were able to use the existing CY 2009 claims and most current cost report data to create a simulated median cost.

Specifically, to estimate the hospital costs of CPT code 64568 based on its CY 2011 descriptor, we used CY 2009 claims and the most recent cost report data, using the single and "pseudo" single claims within this data set to simulate the new CY 2011 definition of this service. Specifically, we selected claims with CPT code 64573 on which CPT code 61885 or 61886 was also present and consistent with the description of the new CPT code 64568, and we treated the summed costs on these claims as if they were a single procedure claim for CPT code 64568. We created an estimated median cost of approximately $22,562 for CPT code 64568 from 298 single claims to set a final payment rate for CY 2011 for the new code. We are creating new APC 0318 (Implantation of Cranial Neurostimulator Pulse Generator and Electrode) for CY 2011, to which CPT code 64568 is the only procedure assigned. APC 0225 (Implantation of Neurostimulator Electrodes, Cranial Nerve), which contained only the predecessor CPT code 64573, is deleted effective January 1, 2011.

We note that because CPT code 64568 is new for CY 2011, it is identified with comment indicator "NI" in Addendum B of this final rule with comment period to identify it as subject to public comment. We are specifically requesting public comment on our methodology for simulating the median cost for this new CY 2011 CPT code, in addition to public comments on the payment rate itself.

(10) Cardiac and Intensive Cardiac Rehabilitation (APC 0095)

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60566 through 60574), we implemented the provisions of section 144(a) of the Medicare Improvements for Patients and Providers Act (MIPPA, Pub. L. 110–275). Section 144(a) of Public Law 110–275 amended the Act to expand Medicare Part B coverage for cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) services furnished to beneficiaries with certain conditions, effective January 1, 2010. Section 144(a) of Public Law 110–275 also expanded coverage for pulmonary rehabilitation. Section 1861(eee)(4)(C) of the Act provides for up to 72 one-hour sessions of ICR with up to 6 sessions per day, over a period of 18 weeks. Medicare limits the number of cardiac rehabilitation program sessions to a maximum of 2 1-hour sessions per day, for up to 36 sessions, over up to 36 weeks. Medicare contractors have the authority to approve additional CR sessions, up to 72 total sessions, over an additional period of time. Section 144(a)(2) of Pub. Law 110–275 also includes specific language governing payment for services furnished in an ICR program under the MPFS, including a requirement that the Secretary shall substitute the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department services under the OPPS.

Last year, we also finalized our requirement that all ICR programs be approved through the NCD process. Once we have approved an ICR program or programs through the NCD process, individual sites wishing to furnish ICR items and services via an approved ICR program may enroll with their local Medicare contractor to become an ICR program supplier as outlined in § 424.510. This enrollment is designed to ensure that the specific sites meet the specific statutory and regulatory requirements to furnish these services and will provide a mechanism to appeal a disapproval of a prospective ICR program site. With regards to billing and payment for CR and ICR services, we stated that hospital providers will continue to use their CMS Certification Number (CCN or provider number) and that appeals related to the payment of claims will follow those established processes.

For CY 2010, we finalized two new HCPCS codes G0422 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring, with exercise, per hour, per session) and G0423 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring, without exercise, per hour, per session) to describe intensive cardiac rehabilitation and accompany the CPT codes for cardiac rehabilitation already recognized for payment under the OPPS: CPT codes 93797 (Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)) and 93798 (Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)). We finalized payment for all of these HCPCS codes in APC 0095 with a payment rate of approximately $38 per session. We noted our belief that hospital costs for a single session would be similar and that OPPS payment for both CR and ICR services would be provided on a per session basis (74 FR 60571). Because there were historic claims data for CR services, we used our standard methodology to estimate a median cost and $38 payment rate for CR and ICR services.

As discussed in section II.A.2 of this final rule with comment period, the standard OPPS rate setting methodology we used to establish a median cost for APC 0095 relies upon converting hospital charges for CPT codes 97397 and 97398 on claims to costs using hospital-specific cost-to-charge ratios (CCRs) from the hospital's Medicare cost report and crosswalking them to claim services based on a "revenue code-to-cost center crosswalk" that matches the revenue codes on a claim to a hierarchy of cost centers. The OPPS uses this uniform approach to setting the cost-based relative payment weights for its payment groups, and these annually updated cost-based weights are the basis for the prospective payment rates for hospital outpatient services.

In 2008, the results of a study by RTI International (RTI) commissioned by CMS indicated that cost estimates for CR services may be under-estimated ("Refining Cost to Charge Ratios for Calculating APC and MS–DRG Relative Payment Weights: Final Report"

available at *http://www.rti.org/reports/cms/HHSM–500–2005–0029I/PDF/Refining_Cost_to_Charge_Ratios_200807_Final.pdf*). Specifically, RTI indicated that several changes in cost reporting methods would result in a more accurate estimated median cost. Accordingly, in February 2010, CMS established a CR-specific cost center for voluntary use on the cost report to create a CR-specific CCR and thereby improve the accuracy of cost estimation. However, we will not have the new cost report data available for ratesetting until CY 2013. We did not propose to use interim data from the new cost center to set CY 2011 payment rates because, as we previously explained, we would have to modify the data from its submitted form and make assumptions in a methodology that would be contrary to our principle of using data as submitted by hospitals in OPPS ratesetting (74 FR 60571 and 73 FR 68525).

Comment: One commenter indicated that the finalized payment of $38 is too low for ICR services, does not cover the extensive cost to providers to offer these services, and that many providers are closing due to insufficient payment. The commenter cited the RTI report again as a source of key recommendations to improve CMS cost estimation methodology. The commenter indicated that, in comparison to RTI's finding of about $100 median cost after incorporating all recommendations, the CMS proposed payment rate of about $39 is artificially low. The commenter suggested that CMS possesses special authority to conduct payment evaluations and make changes for services that are being implemented under national coverage determinations. With respect to ICR services, the commenter indicated that while more resources are consumed than during traditional CR programs in terms of hospital, physician, and patient commitments, ICR services are more efficacious and yield better outcomes than alternative treatment measures not only for cardiac conditions but also for comorbidities such as obesity and diabetes. The commenter stated that Congress recognized these principles in subjecting ICR programs to a heightened demonstration of efficacy through a series of measures, as proved through peer-reviewed literature. The commenter also stated that the two ICR demonstration programs at Highmark Blue Cross Blue Shield and Mutual of Omaha evidenced cost savings.

Response: In response to the commenter, we revisited RTI's study. In further reviewing its recommendations, we agree with the commenter that payment for CR and ICR services could be improved in this final rule with comment period. Specifically, we believe that, in addition to adding the non-standard cost center, we may improve the accuracy of payment for CR and ICR services by incorporating a second policy that was recommended in the RTI study. RTI also recommended that we incorporate a clinic CCR into the "revenue code-to-cost center crosswalk" for cardiac rehabilitation as we did for pulmonary rehabilitation last year. Therefore, we will add a clinic cost center to revenue code-to-cost center crosswalk for the hierarchy of cost centers used to estimate costs from charges for revenue code 0943 for cardiac rehabilitation. With this revision, the estimated median cost for CR services rises to $68.08. We are establishing $68.08 as the median cost for APC 0095 for CR and ICR services. We also believe that there are other revenue codes for OPPS clinic services that could include a clinic CCR in their hierarchy, and we will assess potential changes to the crosswalk for CY 2012.

This policy would follow RTI's general approach of including a clinic revenue code for services provided in the clinic setting, which we incorporated last year for pulmonary rehabilitation when we updated the crosswalk by adding a clinic CCR into the hierarchy for the PR revenue code 0948 (74 FR 60347). Adding a clinic revenue code to the crosswalk is consistent with our approach of having up to four tiers in our hierarchy of cost centers used to apply CCRs to charges by revenue code on claims data. We also note that the specific new benefits of CR and PR are similar under the OPPS and that the authorizing statute defines comparable components for CR, ICR, and PR services, which we believe supports using a comparable cross-walk approach for these services.

We appreciate the commenter's information on the efficacy of ICR programs and their cost effectiveness, but note that this has no bearing on establishing payments under the OPPS. Also, we disagree with the commenter that the facility resources required to provide a one hour session of ICR services differ from the resources required to provide a one hour session of CR. In our CY 2010 OPPS/ASC final rule with comment period, we noted our belief that hospital costs for a single session would be similar and that OPPS payment for both CR and ICR services would be provided on a per session basis (74 FR 60571). Therefore, because we believe that CR and ICR services are similar from a per hour resource perspective, we will continue to assign the CPT codes for both CR and ICR services per hour to the same APC for CY 2011. However, because we implemented HCPCS codes G0422 and G0423 in CY 2010, we will have historic charge information specific to ICR programs for CY 2012 ratesetting, and we will reevaluate whether estimated costs for ICR are sufficiently different from standard CR services to warrant proposing placement in a different APC. Finally, when the new cost report information becomes available beginning in CY 2013, we will reassess placement of CR and ICR in the same APC.

e. Calculation of Composite APC Criteria-Based Median Costs

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

At its February 2010 meeting, the APC Panel recommended that, in order to support stem cell transplantation, CMS consider creating a composite APC or custom APC that captures the costs of stem cell acquisition performed in conjunction with recipient transplantation and preparation of tissue. In the CY 2011 OPPS/ASC

proposed rule (75 FR 46208), we indicated that we were accepting this APC Panel recommendation to consider creating a composite APC or custom APC that captures the costs of stem cell acquisition performed in conjunction with recipient transplantation and preparation of tissue, and would report the results of our assessment to the APC Panel at a future meeting.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46208), for CY 2011, we proposed to continue our established composite APC policies for extended assessment and management, LDR prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, mental health services, and multiple imaging services, as discussed in sections II.A.2.e.(1), II.A.2.e.(2), II.A.2.e.(3), II.A.2.e.(4), and II.A.2.e.(5), respectively, of the proposed rule and this final rule with comment period.

Comment: A number of commenters recommended that we establish new composite APCs in the clinical areas of cardiac resynchronization therapy (CRT) and stem cell transplantation. Regarding a request for a new CRT composite APC, a few commenters stated that a CRT composite is appropriate, recalling that the APC Panel at its February and August 2009 meetings recommended that we evaluate the implications of the creation of a new composite APC for CRT and recommended that we reconsider creating a composite APC or group of composite APCs for CRT. The commenters were concerned that we have not yet reported back to the APC Panel with an evaluation or a proposed composite APC for CRT services. Some commenters noted that the procedures involved with implantation of CRT, CRT with defibrillator (CRT–D) or CRT with pacemaker (CRT–P) are never captured in claims data as single bills, which we use in our standard ratesetting methodology; rather, the correctly coded CRT services always involve the submission of two CPT codes on the same claim. These commenters asserted that the CY 2011 proposed rule claims data demonstrate that the percentage of single claims available for use in CRT ratesetting is very low compared to the total number of claims submitted for CRT–D or CRT–P services. The result, the commenters claimed, is payment fluctuations over the years for APC 0418 (Insertion of Left Ventricular Pacing Electrode), which a CRT composite APC payment methodology will lessen through a more robust set of claims.

Several commenters supported the APC Panel's recommendation and welcomed our acceptance of that APC Panel recommendation to consider creating a composite APC or custom APC that captures the costs of stem cell acquisition performed in conjunction with recipient transplantation and preparation of tissue.

Response: While we continue to consider the development and implementation of larger payment bundles, such as composite APCs (a long-term policy objective for the OPPS), and continue to explore other areas where this payment model may be utilized, in the CY 2011 OPPS/ASC proposed rule, we did not propose any new composite APCs for CY 2011 so that we may monitor the effects of the existing composite APCs on utilization and payment, similar to our treatment of the composite APC methodology mentioned in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60391). As indicated below, we have accepted the APC Panel recommendations to consider composite APCs for CRT, and we will reconsider whether it would be appropriate to propose in the future composite APCs for CRT services and evaluate the implications of such a potential policy change, and report our findings to the APC Panel at a future meeting. We note that several commenters to the CY 2011 proposed rule supported that we did not propose any new composite APCs for CY 2011, such as new multiple imaging APCs, without public notice and comment.

As noted by a few commenters, at its February 2009 meeting, the APC Panel recommended that CMS evaluate the implications of creating composite APCs for CRT services with a defibrillator or pacemaker and report its findings to the APC Panel. The APC Panel also recommended at its August 2009 meeting that CMS reconsider creating a new composite APC or group of composite APCs for CRT procedures. While we did not propose any new composite APCs for CY 2010 or CY 2011, we accepted both of these APC Panel recommendations, as noted in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60391). We will reconsider proposing to create composite APCs for CRT services and evaluate the implications of such a potential policy change, and report our findings to the APC Panel at a future meeting. As discussed in the 2011 OPPS/ASC proposed rule (75 FR 46208), we accepted the APC Panel recommendation made at its February 2010 meeting, that we consider creating a composite APC or custom APC that captures the costs of stem cell acquisition performed in conjunction with recipient transplantation and preparation of tissue. We also will consider bringing other potential composite APCs to the APC Panel for further discussion.

After consideration of the public comments we received, for CY 2011, we are finalizing, without modification, our proposal to continue our established composite APC policies for extended assessment and management, LDR prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, mental health services, and multiple imaging services, as discussed in sections II.A.2.e.(1), II.A.2.e.(2), II.A.2.e.(3), II.A.2.e.(4), and II.A.2.e.(5), respectively, of this final rule with comment period.

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46208), we proposed to continue to include composite APC 8002 (Level I Extended Assessment and Management Composite) and composite APC 8003 (Level II Extended Assessment and Management Composite) in the OPPS for CY 2011. For CY 2008, we created these two composite APCs to provide payment to hospitals in certain circumstances when extended assessment and management of a patient occur (an extended visit). In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. In the circumstances when observation care is provided in conjunction with a high level visit or direct referral and is an integral part of a patient's extended encounter of care, payment is made for the entire care encounter through one of two composite APCs as appropriate.

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

payment through a composite APC is inappropriate, the I/OCE, in conjunction with the OPPS Pricer, determines the appropriate status indicator, APC, and payment for every code on a claim. The specific criteria that must be met for the two extended assessment and management composite APCs to be paid are provided below in the description of the claims that were selected for the calculation of the proposed CY 2011 median costs for these composite APCs. We did not propose to change these criteria for the CY 2011 OPPS.

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46209), for CY 2011, we proposed to continue the extended assessment and management composite APC payment methodology for APCs 8002 and 8003. We stated in the proposed rule that we continue to believe that the composite APCs 8002 and 8003 and related policies provide the most appropriate means of paying for these services. We proposed to calculate the median costs for APCs 8002 and 8003 using all single and "pseudo" single procedure claims for CY 2009 that meet the criteria for payment of each composite APC.

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

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

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

3. Contained one of the following codes:

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

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

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

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

Comment: One commenter supported CMS' policy to package payment for observation care and to not provide additional payment through an extended assessment and management composite APC payment when observation services are billed with significant surgical procedures. According to the commenter, the observation services in such cases are most likely related to post-procedural recovery, and thus no additional payment is warranted. The commenter stated that minor procedures with extended observation care, on the other hand, should be eligible for additional payment through APCs 8002 and 8003.

Response: We appreciate the commenter's support of our policy not to allow payment of APC 8002 or 8003 for claims that include a HCPCS code to which we have assigned status indicator

"T" that is reported with a date of service on the same day as or one day prior to the date of the service associated with HCPCS code G0378. We agree that payment for such services is included in the payment for the surgical procedure. It is unclear to us exactly how the commenter defines minor procedures; however, we do allow payment of APCs 8002 and 8003 when ancillary services with status indicator "X" or packaged services with status indicator "N" appear on the same claim as HCPCS code G0378.

Comment: One commenter recommended that CMS consider adopting the National Universal Billing Committee (NUBC) guidelines, utilized by private insurance carriers, which permit payment for observation care furnished during the time of an inpatient hospital stay that is subsequently overturned by a hospital's utilization review committee.

Response: This comment is outside of the scope of the proposals in the CY 2011 OPPS/ASC proposed rule. However, we will consider the possibility of addressing this concern through other available mechanisms, as appropriate. We note that we have continued to emphasize that observation care is a hospital outpatient service, ordered by a physician and reported with a HCPCS code, like any other outpatient service. It is not a patient status for Medicare payment purposes.

After consideration of the public comments we received, we are adopting as final, without modification, our CY 2011 proposal to continue to include composite APCs 8002 and 8003 in the OPPS and to continue the extended assessment and management composite APC payment methodology and criteria that we finalized for CYs 2009 and 2010. We also are calculating the median costs for APCs 8002 and 8003 using all single and "pseudo" single procedure claims from CY 2009 that meet the criteria for payment of each composite APC. The final CY 2011 median cost resulting from this methodology for APC 8002 is approximately $390, which was calculated from 19,156 single and "pseudo" single bills that met the required criteria. The final CY 2011 median cost for composite APC 8003 is approximately $707, which was calculated from 221,246 single and "pseudo" single bills that met the required criteria.

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

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

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46210), for CY 2011, we proposed to continue paying for LDR prostate brachytherapy services using the composite APC methodology proposed and implemented for CYs 2008, 2009, and 2010. That is, we proposed to use CY 2009 claims on which both CPT codes 55875 and 77778 were billed on the same date of service with no other separately paid procedure codes (other than those on the bypass list) to calculate the payment rate for composite APC 8001. Consistent with our CY 2008 through CY 2010 practice, we proposed not to use the claims that meet these criteria in the calculation of the median costs for APCs 0163 (Level IV Cystourethroscopy and Other Genitourinary Procedures) and 0651 (Complex Interstitial Radiation Source Application), the APCs to which CPT codes 55875 and 77778 are assigned, respectively. The median costs for APCs 0163 and 0651 would continue to be calculated using single and "pseudo" single procedure claims. We indicated in the proposed rule that we continue to believe that this composite APC contributes to our goal of creating hospital incentives for efficiency and cost containment, while providing hospitals with the most flexibility to manage their resources. We also continue to believe that data from claims reporting both services required for LDR prostate brachytherapy provide the most accurate median cost upon which to base the composite APC payment rate.

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

claims we believe to be correctly coded, would result in a reasonable and appropriate payment rate for this service in CY 2011.

Comment: One commenter expressed appreciation for the proposed payment increase for composite APC 8001 based on an increase in median costs, and recommended that CMS finalize the proposed CY 2011 payment rate. Another commenter was concerned that the 788 claims with both CPT codes 55875 and 77778 were used for development of the proposed CY 2011 payment rate for APC 8001 was an extremely low number of claims compared to the number of these procedures performed in hospitals for cancer patients, and encouraged CMS to explore ways to capture more multiple claims to be used in future ratesetting for composite APC 8001.

Response: We appreciate the commenter's support for our proposed payment rate for composite APC 8001. Regarding the commenter's concern with the number of CY 2011 proposed rule claims used for APC 8001 proposed rate, for the CY 2011 final rule with comment period, we have 849 claims that contain both CPT codes 55875 and 77778 to calculate the median cost of APC 8001 of approximately $3,195. We believe this is a robust number of claims from which to calculate accurate and appropriate payment rates for the services assigned to APC 8001. For all OPPS services, we continue our efforts to use the data from as many multiple procedure claims as possible, through approaches such as use of the bypass list and date splitting of claims as described further in section II.A. of this final rule with comment period, and through methodologies such as increased packaging and composite APCs.

After consideration of the public comments we received, we are finalizing, without modification, our proposal to continue paying for LDR prostate brachytherapy services using the composite APC methodology implemented for CYs 2008, 2009, and 2010 described above in this section. The final CY 2011 median cost for composite APC 8001 is approximately $3,195 calculated from 849 single bills.

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

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

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46210), for CY 2011, we proposed to continue to pay for cardiac electrophysiologic evaluation and ablation services using the composite APC methodology proposed and implemented for CY 2008, CY 2009, and CY 2010. Consistent with our CY 2008 through CY 2010 practice, we proposed not to use the claims that meet the composite payment criteria in the calculation of the median costs for APC 0085 and APC 0086, to which the CPT codes in both groups A and B for composite APC 8000 are otherwise assigned. Median costs for APCs 0085 and 0086 would continue to be calculated using single procedure claims. As we indicated in the proposed rule, we continue to believe that the composite APC methodology for cardiac electrophysiologic evaluation and ablation services is the most efficient and effective way to use the claims data for the majority of these services and best represents the hospital resources associated with performing the common combinations of these services that are clinically typical. Furthermore, this approach creates incentives for efficiency by providing a single payment for a larger bundle of major procedures when they are performed together, in contrast to continued separate payment for each of the individual procedures.

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

Comment: One commenter supported CMS' proposal to continue to pay for cardiac electrophysiologic evaluation and ablation services using composite APC 8001, as the most efficient and

effective way to use claims data for these services.

Response: We appreciate the supportive comment, and agree that composite APC 8001 promotes efficient use of resources and results in accurate and appropriate payment rates for cardiac electrophysiologic evaluation and ablation services.

After consideration of the public comments received, we are finalizing our proposal, without modification, to continue to pay for cardiac electrophysiologic evaluation and ablation services using the composite APC methodology implemented for CY 2008, CY 2009, and CY 2010. For this final rule with comment period, we were able to use 9,736 claims from CY 2009 containing a combination of group A and group B codes and calculated a final CY 2011 median cost of approximately $10,673 for composite APC 8000. Table 12 below lists the groups of procedures upon which we based composite APC 8000 for CY 2011.

TABLE 12—GROUPS OF CARDIAC ELECTROPHYSIOLOGIC EVALUATION AND ABLATION PROCEDURES UPON WHICH COMPOSITE APC 8000 IS BASED

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

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46211), we proposed to continue our longstanding policy of limiting the aggregate payment for specified less resource-intensive mental health services furnished on the same date to the payment for a day of partial hospitalization, which we consider to be the most resource-intensive of all outpatient mental health treatment for CY 2011. We refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18452 through 18455) for the initial discussion of this longstanding policy. We continue to believe that the costs associated with administering a partial hospitalization program represent the most resource-intensive of all outpatient mental health treatment. Therefore, we do not believe that we should pay more for a day of individual mental health services under the OPPS than the partial hospitalization per diem payment.

As discussed in detail in section X. of the CY 2011 OPPS/ASC proposed rule (75 FR 46298 through 46301) and this final rule with comment period, for CY 2011, we proposed to use a provider-specific two tiered payment approach for partial hospitalization services that distinguishes payment made for services furnished in a CMHC from payment made for services furnished in a hospital. Specifically, we proposed one APC for partial hospitalization program days with three services furnished in a CMHC (APC 0172, Level I Partial Hospitalization (3 services) for CMHCs) and one APC for days with four or more services furnished in a CMHC (APC 0173, Level II Partial Hospitalization (4 or more services) for CMHCs). We proposed that the payment rates for these two APCs be based upon the median per diem costs calculated using data only from CMHCs. Similarly, we proposed one APC for partial hospitalization program days with three services furnished in a hospital (APC 0175, Level I Partial Hospitalization (3 services) for Hospital-Based PHPs), and one APC for days with four or more services furnished in a hospital (APC 0176, Level II Partial Hospitalization (4 or more services) for Hospital-Based PHPs). We proposed that the payment rates for these two APCs be based on the median per diem costs calculated using data only from hospitals.

Because our longstanding policy of limiting the aggregate payment for specified less resource-intensive mental health services furnished on the same date to the payment rate for the most resource-intensive of all outpatient mental health treatment, we proposed to set the CY 2011 payment rate for APC 0034 (Mental Health Services Composite) at the same rate as we proposed for APC 0176, which is the maximum partial hospitalization per diem payment. As we stated in the CY 2011 OPPS/ASC proposed rule (75 FR 46212), we believe this APC payment rate would provide the most appropriate payment for composite APC 0034, taking into consideration the intensity of the mental health services and the differences in the HCPCS codes for mental health services that could be paid through this composite APC compared with the HCPCS codes that could be paid through partial hospitalization APC 0176. When the aggregate payment for specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services exceeds the maximum per diem partial hospitalization payment, we proposed that those specified mental health services would be assigned to APC 0034. We proposed that APC 0034 would have the same payment rate as APC 0176 and that the hospital would continue to be paid one unit of APC

0034. The I/OCE currently determines, and we proposed for CY 2011 that it would continue to determine, whether to pay these specified mental health services individually or to make a single payment at the same rate as the APC 0176 per diem rate for partial hospitalization for all of the specified mental health services furnished by the hospital on that single date of service.

Comment: Many commenters strongly supported the CMS proposal to use the hospital-based partial hospitalization APC 0176 (4 or more units of service) as the daily payment cap for less intensive mental health services provided in hospital outpatient departments.

Response: We appreciate the commenters' support for utilizing the hospital-based partial hospitalization APC 0176 (4 or more units of service) as the daily payment cap for less intensive mental health services provided in hospital outpatient departments. We continue to believe that the costs associated with administering a partial hospitalization program represent the most resource intensive of all outpatient mental health treatment, and we do not believe CMS should pay more for a day of individual mental health services under the OPPS.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to limit the aggregate payment for specified less intensive outpatient mental health services furnished on the same date by a hospital to the payment for a day of partial hospitalization, specifically APC 0176.

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

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

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

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

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

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

At its February 2010 meeting, the APC Panel recommended that CMS continue providing analysis on an ongoing basis of the impact on beneficiaries of the multiple imaging composite APCs as data become available. In the CY 2011 OPPS/ASC proposed rule, we indicated that we are accepting this recommendation and will provide the requested analysis to the APC Panel at a future meeting.

In summary, for CY 2011, we proposed to continue paying for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite payment methodology. The proposed CY 2011 payment rates for the five multiple imaging composite APCs (APC 8004, APC 8005, APC 8006, APC 8007, and APC 8008) were based on median costs calculated from the partial year CY 2009 claims available for the proposed rule that would have qualified for composite payment under the current policy (that is, those claims with more than one procedure within the same family on a single date of service). To calculate the proposed median costs, we used the same methodology that we used to calculate the final CY 2010 median costs for these composite APCs. That is, we removed any HCPCS codes in the OPPS imaging families that overlapped with codes on our bypass list ("overlap bypass codes") to avoid splitting claims with multiple units or multiple occurrences of codes in an OPPS imaging family into new "pseudo" single claims. The imaging HCPCS codes that we removed from the bypass list for purposes of calculating the proposed multiple imaging composite APC median costs appeared in Table 8 of the proposed rule. (We note that, consistent with our proposal in section II.A.1.b. of the proposed rule to add CPT code 70547 (Magnetic resonance angiography, neck; without contrast material(s)) to the list of bypass codes for CY 2011, we also proposed to add CPT code 70547 to the list of proposed OPPS imaging family services overlapping with HCPCS codes on the proposed CY 2010 bypass list.) We integrated the identification of imaging composite "single session" claims, that is, claims with multiple imaging procedures within the same family on the same date of service, into the creation of "pseudo" single procedure claims to ensure that claims were split in the "pseudo" single process into accurate reflections of either a composite "single session" imaging service or a standard sole imaging

service resource cost. Like all single bills, the new composite "single session" claims were for the same date of service and contained no other separately paid services in order to isolate the session imaging costs. Our last step after processing all claims through the "pseudo" single process was to reassess the remaining multiple procedure claims using the full bypass list and bypass process in order to determine if we could make other "pseudo" single bills. That is, we assessed whether a single separately paid service remained on the claim after removing line-items for the "overlap bypass codes."

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

Comment: A large number of commenters were concerned with the composite APC policy for imaging services, and recommended separate payment for all imaging procedures regardless of whether multiple procedures are performed during the same session. Commenters supported the fact that CMS did not propose new composite APCs or to expand the multiple imaging composite APC policy for CY 2011, opining that no expansion of the imaging composite APCs should be considered until substantial data on the initial five APCs are available for public review and comment. The commenters further recommended that future proposals for expanding the imaging composite APCs should be subject to public notice and comment. A few commenters suggested that CMS undertake robust data collection to determine if imaging costs are correctly captured. Other commenters appreciated our proposed increases in payment for multiple imaging composite APCs. However, the commenters were concerned that the multiple imaging composite APC payment rates remained insufficient to reflect the current costs of diagnostic imaging procedures, particularly when more than two imaging procedures are performed. One commenter recommended that we evaluate whether the methodology used to establish existing composite APCs results in payments that accurately reflect all of the resources needed to perform these services. A number of commenters voiced agreement with the APC Panel's recommendation that we continue to provide analyses on an ongoing basis of the impact on beneficiaries of the multiple imaging composite APC methodology as data becomes available.

One commenter requested separate payment when imaging services of the same modality are performed on the same day but at different times. The commenter claimed that for some patients, such as cancer or trauma patients, such protocols are essential for safety and efficacy, and that the same economies of scale that can be achieved by performing multiple imaging procedures during the same sitting may not be realized if a significant amount of time passes between the first and subsequent imaging procedures. The commenter recommended that CMS implement a modifier or condition code to distinguish between imaging services performed during the same sitting and imaging services performed at different times on the same day.

Another commenter opposed the multiple imaging composite APCs, stating that the policy penalizes specific imaging services under the guise of creating incentives for efficiencies, which will not be achieved because payment rates are already very low under the Deficit Reduction Act. The commenter further asserted that hospitals will be encouraged to perform imaging studies on separate days to avoid payment under composite APCs, thus causing inconvenience to Medicare beneficiaries.

Response: We appreciate the support for our decision not to propose any new composite APCs for CY 2011, and for the proposed CY 2011 payment rate for the multiple imaging composite APCs. We would subject any future proposals on composite APCs to public notice and opportunity for comment through our normal rulemaking process. As noted previously, we are accepting the APC Panel recommendation to provide analysis on an ongoing basis of the impact on beneficiaries of the multiple imaging composite APCs as data become available, which would include analysis of whether imaging costs are correctly captured. We do not agree with the comments that the composite APC payment rates are insufficient to reflect the current costs of diagnostic imaging procedures when more than two imaging procedures are performed. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60400), we do not believe that, in aggregate, OPPS payment for multiple imaging services will be inadequate under the multiple imaging composite APC payment methodology so as to limit beneficiary access, even considering the minority of cases in which hospitals provide more than two imaging procedures on a single date of service. The median costs upon which the payment rates for the multiple imaging composite APCs are based are calculated using CY 2009 claims that would have qualified for composite payment, including those with only two imaging procedures and those with substantially higher numbers of imaging procedures. Payment based on a measure of central tendency is a principle of any prospective payment system. In some individual cases, payment exceeds the average cost and in other cases payment is less than the average cost. On balance, however, payment should approximate the relative cost of the average case, recognizing that, as a prospective payment system, the OPPS is a system of averages. Moreover, consistent with our policy regarding APC payments made on a prospective basis, multiple composite imaging services are subject to the outlier provision of section 1833(t)(5) of the Act for high cost cases meeting specific conditions. We also do not agree with the commenters that the multiple imaging composite APC payment methodology will result in hospitals requiring patients who need more than two imaging procedures to return for additional sittings on other days. As we stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68562), we do not believe that, in general, hospitals would routinely and for purposes of financial gain put patients at unnecessary risk of harm from radiation or contrast exposure, or inconvenience them or risk lack of timely follow-up to the point of making them return to the hospital on separate days to receive medically necessary diagnostic studies. However, we again note that we do have the capacity to examine our claims data for patterns of fragmented care. If we were to find a pattern in which a hospital appears to be fragmenting imaging services across multiple days for individual beneficiaries, we could refer it for review by the Quality Improvement Organizations (QIOs) with respect to the quality of care furnished, or for review by the Program Safeguard Contractors of claims against the medical record, as appropriate to the circumstances we found.

As we stated in the CY 2010 final rule with comment period (74 FR 60399), we do not agree with the commenters that multiple imaging procedures of the same modality provided on the same date of service but at different times

should be exempt from the multiple imaging composite payment methodology. As we indicated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68565) and the CY 2010 OPPS/ASC final rule with comment period (74 FR 60399), we believe that composite payment is appropriate even when procedures are provided on the same date of service but at different times because hospitals do not expend the same facility resources each and every time a patient is seen for a distinct imaging service in a separate imaging session. In most cases, we expect that patients in these circumstances would receive imaging procedures at different times during a single prolonged hospital outpatient encounter. The efficiencies that may be gained from providing multiple imaging procedures during a single session are achieved in ways other than merely not having to reposition the patient. Even if the same level of efficiencies could not be gained for multiple imaging procedures performed on the same date of service but at different times, we expect that any higher costs associated with these cases would be reflected in the claims data and cost reports we use to calculate the median costs for the multiple imaging composite APCs and, therefore, in the payment rates for the multiple imaging composite APCs. Therefore, we do not believe it is necessary or appropriate for hospitals to report imaging procedures provided on the same date of service but during different sittings any differently than they would report imaging procedures performed consecutively in one sitting with no time in between the imaging services. In addition, for the above reasons, we do not believe it is necessary to implement a modifier or condition code to distinguish between such cases.

We disagree with the commenter that multiple imaging composite APCs penalize specific imaging services rather than create incentives for efficiencies, and that efficiencies cannot be achieved because payment rates are already very low under the DRA. As stated in the CY 2009 OPPS/ASC final rule with comment period (72 FR 66613) and previously in this section, we believe that combining payment for multiple independent services into a single OPPS payment in this way enables hospitals to manage their resources with maximum flexibility by monitoring and adjusting the volume and efficiency of services themselves. The DRA does not reduce OPPS payment rates for imaging, so we do not agree that this contributes in any way to payment rates for imaging services that are too low under the OPPS.

After consideration of the public comments we received, we are adopting our CY 2011 proposal, without modification, to continue paying for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite payment methodology. The CY 2011 payment rates for the five multiple imaging composite APCs (APC 8004, APC 8005, APC 8006, APC 8007, and APC 8008) are based on median costs calculated from the CY 2009 claims that would have qualified for composite payment under the current policy (that is, those claims with more than one procedure within the same family on a single date of service). Using the same ratesetting methodology described in the CY 2011 OPPS/ASC proposed rule (75 FR 46213), we were able to identify 1.9 million "single session" claims out of an estimated 2.9 million potential composite cases from our ratesetting claims data, or well over half of all eligible claims, to calculate the final CY 2011 median costs for the multiple imaging composite APCs.

Table 13 below lists the HCPCS codes that will be subject to the multiple imaging composite policy and their respective families for CY 2011. We note that we have updated Table 13 to reflect HCPCS coding changes for CY 2011. Specifically, we added CPT code 74176 (Computed tomography, abdomen and pelvis; without contrast material), CPT code 74177 (Computed tomography, abdomen and pelvis; with contrast material(s)), and CPT code 74178 (Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions) to the CT and CTA family. These codes are new for CY 2011. We also added codes C8931 (Magnetic resonance angiography with contrast, spinal canal and contents), C8932 (Magnetic resonance angiography without contrast, spinal canal and contents), C8933 (Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents), C8934 (Magnetic resonance angiography with contrast, upper extremity), C8935 (Magnetic resonance angiography without contrast, upper extremity), and C8936 (Magnetic resonance angiography without contrast followed by with contrast, upper extremity), to the MRI and MRA family. These codes were recognized for OPPS payment in the October 2010 OPPS Update (Transmittal 2050, Change Request 7117, dated September 17, 2010). The HCPCS codes listed in Table 13 are assigned status indicated "Q3"' in Addendum B to this final rule with comment period to identify their status as potentially payable through a composite APC. Their composite APC assignment is identified in Addendum M to this final rule with comment period. Table 14 below lists the OPPS imaging family services that overlap with HCPCS codes on the CY 2011 bypass list.

TABLE 13—OPPS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCS

Family 1—Ultrasound

CY 2011 APC 8004 (Ultrasound composite)	CY 2011 Approximate APC median
76604	Us exam, chest.
76700	Us exam, abdom, complete.
76705	Echo exam of abdomen.
76770	Us exam abdo back wall, comp.
76775	Us exam abdo back wall, lim.
76776	Us exam k transpl w/ Doppler.
76831	Echo exam, uterus.
76856	Us exam, pelvic, complete.
76870	Us exam, scrotum.
76857	Us exam, pelvic, limited.

Family 2—CT and CTA with and without Contrast

CY 2011 APC 8005 (CT and CTA without Contrast Composite)*	CY 2011 Approximate APC Median Cost = $416
70450	Ct head/brain w/o dye.
70480	Ct orbit/ear/fossa w/o dye.
70486	Ct maxillofacial w/o dye.
70490	Ct soft tissue neck w/o dye.
71250	Ct thorax w/o dye.
72125	Ct neck spine w/o dye.
72128	Ct chest spine w/o dye.
72131	Ct lumbar spine w/o dye.
72192	Ct pelvis w/o dye.
73200	Ct upper extremity w/o dye.
73700	Ct lower extremity w/o dye.
74150	Ct abdomen w/o dye.
74261	Ct colonography, w/o dye.
74176	Ct angio abd & pelvis.

TABLE 13—OPPS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCS—Continued

CY 2011 APC 8006 (CT and CTA with Contrast Composite)	CY 2011 Approximate APC Median Cost = $622
70487	Ct maxillofacial w/dye.
70460	Ct head/brain w/dye.
70470	Ct head/brain w/o & w/ dye.
70481	Ct orbit/ear/fossa w/dye.
70482	Ct orbit/ear/fossa w/o & w/ dye.
70488	Ct maxillofacial w/o & w/ dye.
70491	Ct soft tissue neck w/dye.
70492	Ct sft tsue nck w/o & w/ dye.
70496	Ct angiography, head.
70498	Ct angiography, neck.
71260	Ct thorax w/dye.
71270	Ct thorax w/o & w/dye.
71275	Ct angiography, chest.
72126	Ct neck spine w/dye.
72127	Ct neck spine w/o & w/ dye.
72129	Ct chest spine w/dye.
72130	Ct chest spine w/o & w/ dye.
72132	Ct lumbar spine w/dye.
72133	Ct lumbar spine w/o & w/ dye.
72191	Ct angiograph pelv w/o & w/dye.
72193	Ct pelvis w/dye.
72194	Ct pelvis w/o & w/dye.
73201	Ct upper extremity w/dye.
73202	Ct uppr extremity w/o & w/dye.
73206	Ct angio upr extrm w/o & w/dye.
73701	Ct lower extremity w/dye.
73702	Ct lwr extremity w/o & w/ dye.
73706	Ct angio lwr extr w/o & w/ dye.
74160	Ct abdomen w/dye.
74170	Ct abdomen w/o & w/dye.
74175	Ct angio abdom w/o & w/ dye.
74262	Ct colonography, w/dye.
75635	Ct angio abdominal arteries.
74177	Ct angio abd & pelv w/ contrast.
74178	Ct angio abd & pelv 1+ regns.

* If a "without contrast" CT or CTA procedure is performed during the same session as a "with contrast" CT or CTA procedure, the I/OCE will assign APC 8006 rather than APC 8005.

TABLE 13—OPPS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCS—Continued

Family 3—MRI and MRA with and without Contrast

CY 2011 APC 8007 (MRI and MRA without Contrast Composite)*	CY 2011 Approximate APC Median Cost = $699
70336	Magnetic image, jaw joint.
70540	Mri orbit/face/neck w/o dye.
70544	Mri angiography head w/o dye.
70547	Mri angiography neck w/o dye.
70551	Mri brain w/o dye.
70554	Fmri brain by tech.
71550	Mri chest w/o dye.
72141	Mri neck spine w/o dye.
72146	Mri chest spine w/o dye.
72148	Mri lumbar spine w/o dye.
72195	Mri pelvis w/o dye.
73218	Mri upper extremity w/o dye.
73221	Mri joint upr extrem w/o dye.
73718	Mri lower extremity w/o dye.
73721	Mri jnt of lwr extre w/o dye.
74181	Mri abdomen w/o dye.
75557	Cardiac mri for morph.
75559	Cardiac mri w/stress img.
C8901	MRA w/o cont, abd.
C8904	MRI w/o cont, breast, uni.
C8907	MRI w/o cont, breast, bi.
C8910	MRA w/o cont, chest.
C8913	MRA w/o cont, lwr ext.
C8919	MRA w/o cont, pelvis.
C8932	MRA, w/o dye, spinal canal.
C8935	MRA, w/o dye, upper extr.
CY 2011 APC 8008 (MRI and MRA with Contrast Composite)	CY 2011 Approximate APC Median Cost = $984
70549	Mri angiograph neck w/o & w/dye.
70542	Mri orbit/face/neck w/dye.
70543	Mri orbt/fac/nck w/o & w/ dye.
70545	Mri angiography head w/ dye.
70546	Mri angiograph head w/o & w/dye.
70548	Mri angiography neck w/ dye.
70552	Mri brain w/dye.
70553	Mri brain w/o & w/dye.
71551	Mri chest w/dye.
71552	Mri chest w/o & w/dye.
72142	Mri neck spine w/dye.
72147	Mri chest spine w/dye.
72149	Mri lumbar spine w/dye.
72156	Mri neck spine w/o & w/ dye.
72157	Mri chest spine w/o & w/ dye.
72158	Mri lumbar spine w/o & w/ dye.
72196	Mri pelvis w/dye.
72197	Mri pelvis w/o & w/dye.
73219	Mri upper extremity w/dye.
73220	Mri uppr extremity w/o & w/dye.
73222	Mri joint upr extrem w/ dye.
73223	Mri joint upr extr w/o & w/ dye.
73719	Mri lower extremity w/dye.
73720	Mri lwr extremity w/o & w/ dye.
73722	Mri joint of lwr extr w/dye.
73723	Mri joint lwr extr w/o & w/ dye.
74182	Mri abdomen w/dye.
74183	Mri abdomen w/o & w/ dye.
75561	Cardiac mri for morph w/ dye.
75563	Card mri w/stress img & dye.
C8900	MRA w/cont, abd.
C8902	MRA w/o fol w/cont, abd.
C8903	MRI w/cont, breast, uni.
C8905	MRI w/o fol w/cont, brst, un.
C8906	MRI w/cont, breast, bi.
C8908	MRI w/o fol w/cont, breast,
C8909	MRA w/cont, chest.
C8911	MRA w/o fol w/cont, chest.
C8912	MRA w/cont, lwr ext.
C8914	MRA w/o fol w/cont, lwr ext.
C8918	MRA w/cont, pelvis.
C8920	MRA w/o fol w/cont, pelvis.
C8931	MRA, w/dye, spinal canal.
C8933	MRA, w/o & w/dye, spinal canal.
C8934	MRA, w/dye, upper extremity.
C8936	MRA, w/o & w/dye, upper extr.

* If a "without contrast" MRI or MRA procedure is performed during the same session as a "with contrast" MRI or MRA procedure, the I/OCE will assign APC 8008 rather than 8007.

TABLE 14—OPPS IMAGING FAMILY SERVICES OVERLAPPING WITH HCPCS CODES ON THE CY 2011 BYPASS LIST

Family 1—Ultrasound	
76700	Us exam, abdom, complete.
76705	Echo exam of abdomen.
76770	Us exam abdo back wall, comp.
76775	Us exam abdo back wall, lim.
76776	Us exam k transpl w/ Doppler.
76856	Us exam, pelvic, complete.
76870	Us exam, scrotum.
76857	Us exam, pelvic, limited.

Family 2—CT and CTA with and without Contrast	
70450	Ct head/brain w/o dye.
70480	Ct orbit/ear/fossa w/o dye.
70486	Ct maxillofacial w/o dye.
70490	Ct soft tissue neck w/ o dye.
71250	Ct thorax w/o dye.
72125	Ct neck spine w/o dye.
72128	Ct chest spine w/o dye.
72131	Ct lumbar spine w/o dye.
72192	Ct pelvis w/o dye.
73200	Ct upper extremity w/ o dye.
73700	Ct lower extremity w/ o dye.
74150	Ct abdomen w/o dye.

Family 3—MRI and MRA with and without Contrast	
70336	Magnetic image, jaw joint.
70544	Mri angiography head w/o dye.
70551	Mri brain w/o dye.
72141	Mri neck spine w/o dye.
72146	Mri chest spine w/o dye.
72148	Mri lumbar spine w/o dye.
73218	Mri upper extremity w/o dye.
73221	Mri joint upr extrem w/o dye.
73718	Mri lower extremity w/ o dye.
73721	Mri jnt of lwr extre w/ o dye.

3. Changes to Packaged Services

a. Background

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

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

We assign status indicator "Q1" ("STVX–Packaged Codes"), "Q2" ("T-Packaged Codes"), or "Q3" (Codes that may be paid through a composite APC) to each conditionally packaged HCPCS code. An "STVX-packaged code" describes a HCPCS code whose payment is packaged when one or more separately paid primary services with the status indicator of "S," "T," "V," or "X" are furnished in the hospital outpatient encounter. A "T-packaged code" describes a code whose payment is packaged when one or more separately paid surgical procedures with the status indicator of "T" are provided during the hospital encounter. "STVX-packaged codes" and "T-packaged codes" are paid separately in those uncommon cases when they do not meet their respective criteria for packaged payment. "STVX-packaged codes" and "T-packaged codes" are conditionally packaged. We refer readers to section XIII.A.1. of this final rule with comment period for a complete listing of status indicators.

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

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

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66610 through 66659), we adopted the packaging of payment for items and services in seven categories into the payment for the primary diagnostic or therapeutic modality to which we believe these items and services are typically ancillary and supportive. The seven categories are: (1) Guidance services; (2) image processing services; (3) intraoperative services; (4) imaging

supervision and interpretation services; (5) diagnostic radiopharmaceuticals; (6) contrast media; and (7) observation services. We specifically chose these categories of HCPCS codes for packaging because we believe that the items and services described by the codes in these categories are typically ancillary and supportive to a primary diagnostic or therapeutic modality and, in those cases, are an integral part of the primary service they support.

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

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

b. Packaging Issues

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

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

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

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

At the February 17–18, 2010 APC Panel meeting, we presented subsequent analyses that compared CY 2007 claims processed through September 30, 2007 to CY 2009 claims processed through September 30, 2009. Similar to the initial analysis that we presented to the APC Panel in 2009, the HCPCS codes that we compared are the ones that we identified in the CY 2008 OPPS final rule with comment period as fitting into one of the packaging categories, including HCPCS codes that became effective for CY 2009. As noted above, the seven packaging categories in our CY 2008 packaging proposal are guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast media, and observation services. We note that, similar to the initial analysis, we did not make any adjustments for inflation, changes in the Medicare population, changes in payment due to APC recalibration, changes in frequency due to known changes in code definitions and coding practices, or changes in the population of hospitals paid under the OPPS. A summary of these data analyses is provided below.

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

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

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

guidance services declined by 1 percent between CY 2007 and CY 2009.

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

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

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

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

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

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

We further analyzed the first 9 months of CY 2007 and CY 2009 claims data for radiation oncology services that would be accompanied by radiation oncology guidance. We found that radiation oncology services (including radiation oncology guidance services) were billed approximately 4 million times in CY 2007 and 3.8 million times in CY 2009, representing a decrease in frequency of approximately 6 percent between CY 2007 and CY 2009. These numbers represented each instance where a radiation oncology service or a radiation oncology guidance service was billed. Our analysis indicated that hospitals were paid over $811 million for radiation oncology services and radiation oncology guidance services under the OPPS during the first 9 months of CY 2007, when radiation oncology guidance services were separately payable. During the first 9 months of CY 2009, when payments for radiation oncology guidance were packaged, hospitals were paid over $827 million for radiation oncology services under the OPPS. This $827 million included packaged payment for radiation oncology guidance services and represented a 2-percent increase in aggregate payment from CY 2007 to CY 2009. Using the first 9 months of claims data for both CY 2007 and CY 2009, we calculated an average payment per radiation oncology service or item billed of $199 in CY 2007 and $216 in CY 2009, representing a per service increase of 8 percent from CY 2007 to CY 2009.

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

We conducted these analyses on the specified categories using the first 9 months of claims and cost report data from CY 2007, before the expanded packaging went into effect, and the first 9 months of claims and cost report data from CY 2009—the second year of packaged payment for the radiation guidance services. We found that IMRT services were billed approximately 670,000 times during the first 9 months of CY 2007. During this same timeframe, Medicare paid hospitals approximately $227 million for IMRT services. In comparison, during the first 9 months of CY 2009, IMRT services were billed 713,000 times, representing an increase in frequency of 6 percent. Further, during the first 9 months of CY 2009, when payments for radiation oncology guidance were packaged into the payments for the separately paid IMRT procedures, we paid hospitals over $298 million, representing a 31-percent increase in payments from CY 2007 to CY 2009.

We further analyzed the data for SRS services and found that, for the first 9 months of CY 2007 and CY 2009, SRS services were billed approximately

9,000 and 13,000 times, respectively, representing an increase in frequency of 43 percent. Aggregate Medicare payments for these SRS services increased by 24 percent from $34 million in CY 2007 to $42 million in CY 2009.

Our review of the data for brachytherapy services revealed that, for the first 9 months of CY 2007 and CY 2009, these services were billed approximately 10,000 and 11,000 times, respectively, representing an increase in frequency of 8 percent. During this timeframe, aggregate Medicare payments for these brachytherapy services increased by 1 percent from $9.8 million in CY 2007 to $9.9 million in CY 2009.

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

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

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

During the February 2010 APC panel meeting, the APC Panel accepted the report of the Packaging Subcommittee (the Subcommittee for APC Groups and Status Indicator (SI) Assignments beginning in August 2010) heard several presentations related to packaged services, discussed the deliberations of the Packaging Subcommittee, and made six recommendations. The Report of the February 2010 meeting of the APC Panel may be found at the Web site at: *http://www.cms.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp.*

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

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

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

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

4. The Panel encourages the public to submit common clinical scenarios involving currently packaged HCPCS codes and recommendations of specific services or procedures for which payment would be most appropriately packaged under the OPPS for review by the Packaging Subcommittee members. (Recommendation 4)

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

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

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

Recommendation 1

At the APC Panel's February 2010 meeting, the manufacturer asserted that use of ENB technology during a bronchoscopy procedure enables access to distal lesions that are otherwise not accessible without use of the ENB technology. The manufacturer also argued that without separate payment for ENB, hospitals would likely not adopt the technology and the population that would likely benefit from ENB would not have access to this technology. In response to the manufacturer's assertion, the APC Panel asked CMS to consider whether CPT code 31627, which describes Electromagnetic Navigational Bronchoscopy (ENB), should be packaged or paid separately; and if it should be paid separately, the APC Panel asked CMS to investigate the appropriate APC assignment.

CPT code 31627 is new for CY 2010, and we assigned it a new interim status indicator of "N" in our CY 2010 OPPS/ASC final rule with comment period based on our packaging policies (discussed in section II.A.3.a. of this final rule with comment period). We stated in the proposed rule that we considered the information available to us for CPT code 31627 and believed that the code describes a procedure that is supportive of and ancillary to the primary diagnostic or therapeutic modality, in this case, bronchoscopy procedures (for example, CPT code 31622 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed: Diagnostic, with cell washing, when performed (separate procedure)). We stated that we currently package payment for CPT code 31627,

and that we continued to believe that this is the appropriate treatment of that code. Therefore, in the CY 2011 OPPS/ASC proposed rule (75 FR 46223), we proposed to package payment for CPT code 31627. As we have discussed in past rules, in making our decision on whether to package a service or pay for it separately we consider a variety of factors, including whether the service is normally provided separately or in conjunction with other services because it supports those services. By proposing to packaging payment for this procedure, we would be treating it in the same manner as similar computer-assisted, navigational diagnostic procedures that are supportive of and ancillary to a primary diagnostic or therapeutic modality.

In its recommendation regarding whether to make separate payment under an APC for CPT code 31627, the APC Panel suggested that we use bronchoscopic ultrasonography as a clinical example for comparison. We considered CPT code 31620 (Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure)) to be a suitable comparison because it describes another bronchoscopic procedure in which a guidance technology (that is, ultrasonography) is used to achieve the therapeutic benefit of the procedure. Similar to our proposed payment for CPT code 31627, payment for CPT code 31620 is currently packaged into the primary modality with which it would be appropriately billed. In CY 2008, as part of our increased packaging proposal, we identified the EBUS procedure as an intraoperative ancillary service that would typically be reported in conjunction with an independent service. In addition, similar to CPT code 31627, CPT code 31620 is an add-on code that, in accordance with CPT reporting guidelines, would only be appropriately reported in conjunction with specified bronchoscopy procedures with which it would be performed. Based on these general comparisons of CPT code 31627 to the EBUS procedure described by CPT code 31620, we stated in the proposed rule that we believe that our proposal to package payment for CPT code 31627 would be consistent with the packaging approach that we have adopted in recent years. As we have stated in past rules with regard to EBUS, we also fully expected that, to the extent these services are billed appropriately, payment for the primary service would reflect the cost of the packaged ENB procedure. For example, in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68584), we discussed packaging of CPT code 31620; we state that we observed increased packaged costs associated with the services into which CPT code 31620 had been packaged, which increased the APC payment rates for bronchoscopy procedures.

In summary, we stated in the proposed rule that we continued to believe that CPT code 31627 describes a procedure that is ancillary to and supportive of the primary service with which it is often billed. Therefore, in the CY 2011 OPPS/ASC proposed rule, for CY 2011, we proposed to maintain CPT code 31627 as a packaged service.

The APC Panel at its August 23–24, 2010 meeting heard presentations from the public and discussed whether ENB should remain packaged for CY 2011. We discuss the public comments we received and the Panel recommendation, and provide our response to the public comments on ENB, in section II.A.3.b.(2) of this final rule with comment period.

Recommendation 2

In the CY 2011 OPPS/ASC proposed rule (75 FR 46223), we stated that we did not accept the APC Panel's recommendation that CMS make CPT code 96368 and CPT code 96376 separately payable for the CY 2011 OPPS. We consider a variety of factors in making a decision whether to package a service or pay for it separately, including whether the service is normally provided separately or in conjunction with other services and how likely it is for the costs of the packaged code to be appropriately mapped to the separately payable codes with which it was performed. In the proposed rule, we stated that CPT codes 93676 and 96368 describe concurrent and sequential services that have always been packaged under the OPPS. We stated that from the inception of the OPPS through CY 2006, we paid for drug administration under the OPPS using HCPCS alphanumeric codes that packaged payment for concurrent infusions and administration of new drugs into the payment for the alphanumeric codes for drug administration. In CY 2007, we adopted CPT codes for drug administration services. The CY 2007 CPT codes did not separately recognize administration of new drugs during the same encounter with a separate CPT code. Therefore, administration of a new drug continued to be packaged into payment for the service of which it was a part. Moreover, for CY 2007, CPT code 90768 (Intravenous infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion), which was replaced by CPT code 96368, was packaged under the OPPS, continuing the longstanding practice of not making separate payment for concurrent infusion. We also pointed out that, during our implementation of this new CPT code, while it was new for CY 2007, it represented the same procedures as described by the previous drug administration HCPCS code set, and, as a result, the payment data for these procedures would be captured in the claims that were available to us for ratesetting purposes.

Similarly, CPT codes 96368 and 96376, which were created by CPT in 2008, are replacement codes for those same procedures that were described by the previous drug administration code sets and their associated data would be captured in our claims database. We proposed that the costs for these services, concurrent infusion and additional push of the same drug, would continue to be packaged into payment for the drug administration codes with which they are reported. In the proposed rule, we indicated that we considered a variety of factors, including whether the service is normally provided separately or in conjunction with other services. CPT codes 96368 and 96376 describe concurrent and sequential drug administration services that, in accordance with CPT guidelines, are always provided in association with an initial drug administration service. Therefore, we indicated that we believe that they continue to be appropriately packaged into the payment for the separately payable services that they usually accompany. For example, CPT code 96376 would be billed with CPT code 96374 (Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug), which describes an initial intravenous push code and, as a result, the cost for CPT code 96376 would be reflected in the total cost for CPT code 96374. Moreover, we said that payment for these services has always been packaged into payment for the drug administration services without which they cannot be correctly reported.

In the proposed rule, we stated that these two codes each describe services that, by definition, are always provided in conjunction with an initial drug administration code and that we believed that these services have been packaged since the inception of the OPPS. We further stated that we continued to believe that they are appropriately packaged into the payment for the separately payable services without which, under CPT

guidelines and definition, they cannot be appropriately reported. Therefore, for CY 2011, we proposed to continue our established policy of making packaged payment for CPT code 96368 and CPT code 96376, and we proposed to assign them a status indicator of "N."

Comment: Commenters objected to CMS' proposal to package payment for CPT codes 96376 and 96368 into payment for the services with which they are furnished. The commenters believed that the resources associated with CPT code 96376 are similar to those associated with CPT code 96374 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug) (status indicator "S"). They also believed that while the resources associated with CPT code 96368 somewhat resemble the resources associated with CPT code 96366 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure) (status indicator "S"), they are more similar to the services described by CPT code 96375 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure) (status indicator "S"). The commenters believed that the fact that CPT codes 96376 and 96368 are add-on codes does not preclude them from being separately paid.

Several commenters disagreed with CMS' statement that these services have been packaged since the inception of the OPPS. They stated that hospitals formerly used a single CPT code for reporting IV push administrations, CPT code 90784. They further stated that this code was reported and paid separately for each and every IV push of either the same or different medications. The commenters indicated that when the CPT coding system changed, the payment for the "initial" successor CPT code (90774 [now 96374]) remained virtually identical to the rate for the previous code. Similarly, they indicated that services now reported with CPT code 96368 were historically reported under CPT codes 90780 and 90781 and received separate payment.

Response: As we discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66787 through 66788) and in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68674), in deciding whether to package a service or pay for it separately, we consider a variety of factors, including whether the service is normally provided separately or in conjunction with other services; how likely it is for the costs of the packaged code to be appropriately mapped to the separately payable codes with which it was performed; and whether the expected cost of the service is relatively low. CPT codes 96376 and 96368, by definition, are always provided in association with other drug administration services and the costs of these services are highly likely to be mapped to the separately paid codes with which they are performed and reported. For these reasons, we continue to believe that they are most appropriately packaged under the OPPS. Therefore, we are not accepting the APC Panel's recommendation to pay them separately.

Furthermore, we do not agree with the commenters that the services described by CPT code 96376 are similar to those described by CPT code 96374. CPT code 96374 is an initial intravenous push code, and, per CPT instructions, special billing guidelines apply. Commonly, this service requires the initial establishment of intravenous access in a patient, a resource-intensive task performed by hospital staff using special supplies. In contrast, CPT code 96376 is an add-on code and is reported for each additional sequential intravenous push of the same substance/drug. In the case of this sequential service, the patient already has established intravenous access, so we would expect the service to require fewer hospital resources. In addition, we do not agree with commenters that the services described by CPT code 96368 are similar to those described by CPT code 96375. CPT code 96368 describes a concurrent intravenous infusion while CPT code 96375 describes a sequential intravenous push, and we would expect these services to require different hospital resources because the services require different medical supplies, require different nursing skills, and require different amounts of staff time.

With regard to the comment that the predecessor codes were separately payable until CY 2008 under the OPPS, we acknowledge that CPT code 90784 (Therapeutic, prophylactic or diagnostic injection (specify material injected; intravenous) was separately paid from the inception of the OPPS until its deletion, which was effective December 31, 2005, and might have been reported for an additional sequential intravenous push of the same substance, although the code was not defined as being for an additional sequential push. Similarly, CPT code C8952 (Therapeutic, prophylactic or diagnostic injection; intravenous push of each new substance/drug), which was effective January 1, 2006, and was deleted effective December 31, 2006, also was separately paid during the period that it was effective and might also have been reported for an additional sequential intravenous push of the same substance, although the code was not defined as being for an additional sequential push. CPT code 90776 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (list separately in addition to code for primary procedure)), which was effective January 1, 2008, and deleted effective December 31, 2008, is the first code to specify that the service is an additional sequential intravenous push of the same substance/drug and CPT code 90776 was packaged. Hence, before the creation of CPT code 90776, no code existed to specifically report an additional sequential intravenous push of the same substance; therefore, when the incidental service was furnished, there was no separate payment specifically for this service. We believe that hospital charges for the separately payable codes for the initial administration would have included a charge for this service, and therefore, the payment for it would have been packaged into payment for the separately paid code for the initial administration service. However, we acknowledge that it is possible that hospitals reported the service using separately paid codes that were not defined to be an additional sequential intravenous push of the same substance, in which case we would have paid for the service under the code that was reported. When CPT code 96376, which replaces CPT code 90776, was created effective January 1, 2009, we assigned it the packaged status of its predecessor code, CPT code 90776. For the reasons we articulate above, we disagree with the commenter that predecessor codes were separately payable and continue to believe that we should continue our policy of packaging the payment for the service reported by this code.

With respect to CPT code 96368, we disagree with the commenters that the service has been paid separately since the inception of the OPPS. CPT code 96368 was made effective January 1, 2009, and for CYs 2009 and 2010, we assigned this code to status indicator "N" to indicate that it is a packaged code under the OPPS. Prior to 2009, CPT code 96368 was described by its predecessor CPT code 90768 ((Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify

substance or drug); concurrent infusion), which was also assigned to status indicator "N" from January 1, 2006 through December 30, 2008. Prior to January 2006, there was no specific code that accurately described this service, and as a result, payment for this service was packaged. Therefore, we do not believe that we have paid separately in the past for concurrent intravenous infusions for therapeutic, prophylaxis, or diagnostic purposes under the OPPS.

After consideration of the APC Panel's recommendation and the public comments that we received, we are finalizing our CY 2011 proposal, without modification, to continue to assign HCPCS codes 96368 and 96376 to status indicator "N" to indicate that payment for these codes is packaged into the payment for the primary service with which they are reported.

Recommendation 3

In the CY 2011 OPPS/ASC proposed rule (75 FR 46224), we indicated that we were not accepting the APC Panel's recommendation that we propose to conditionally package CPT codes 19290 (Preoperative placement of needle localization wire, breast), 19291 (Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure)), 19295 (Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)), 77031 (Stereotactic localization guidance for breast biopsy or needle placement (e.g., for wire localization or for injection)), each lesion, radiological supervision and interpretation), 77032 (Mammographic guidance for needle placement, breast (e.g., for wire localization or for injection), each lesion, radiological supervision and interpretation), and 76942 (Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation). During the APC Panel's February 2010 meeting, we shared with the Packaging Subcommittee our most recent claims data for the guidance procedures that would accompany breast needle placement, demonstrating that, for some of these services, the code was billed by itself up to 25 percent of the time. While the Packaging Subcommittee broadly discussed clinical scenarios in which these services may be billed separately, it remains unclear to us why these services are being performed separately and whether they should be paid separately. We believe that these services typically are performed in conjunction with surgical procedures involving the breast and, therefore, are appropriately packaged. Therefore, we indicated that we were not accepting the APC Panel's recommendation that we conditionally package payment for these guidance procedures when they are performed separately.

For CY 2011, we proposed to maintain the unconditional packaged payment status for these procedures. Specifically, we proposed to package payment, indicated by a status indicator of "N," for CPT codes 19290, 19291, 19295, 77031, 77032, and 76942, into the primary modality with which they would be appropriately billed. However, observing such a sizable percentage of services that are the only service appearing on a claim for a packaged item, especially when these services do not receive separate payment, led us to encourage the public to submit any clinical scenarios in their public comments involving these services that show the circumstances under which these services may be appropriately billed without a primary procedure that is furnished on the same date.

Comment: Commenters asked that CMS accept the APC Panel's February 2010 recommendation to conditionally package the placement of needle localization wires and the supporting procedures. Specifically, they asked that CMS permit CPT codes 19290, 19291, 19295, 77031, 77032, and 76942 to be paid when they are not furnished with a service to which we have assigned a payable status indicator (for example, "S," "T," "V," and "X").

Commenters noted that CMS has found that these services are furnished without a base procedure approximately 25 percent of the time. They indicated that they believed that this occurs because the patient is taken to a freestanding radiology center or ASC (which may or may not be located on the hospital campus) with which the hospital has a collaborative arrangement for the non-hospital entity to perform the base procedure and that therefore the hospital does not bill for the base procedure. The commenters believed that the hospitals should be paid for the service that they furnish in these circumstances and, therefore, CMS should change the status of the procedure to conditionally packaged.

Commenters indicated that it is becoming increasingly common for a patient to have a radiographic marker (not a wire exiting the skin, which has the potential for bleeding and infection) on one day, and to have a stereotactic or ultrasound wire localization breast biopsy on a different day. This technique permits intraoperative x-ray verification that the MRI targeted lesion has been removed. The commenters indicated that this is becoming increasingly common with the growing use of breast MRI. They stated that, in addition, some patients undergo image-guided percutaneous placement of a radioactive pellet which is identified days later at the time of surgery using an intraoperative hand held gamma probe. Some surgeon and radiology groups have found that this separation of placement of localization "wire" from the surgical procedure has facilitated scheduling so that any difficulties or delays in the localization do not translate into delay in the operating room. Moreover, they stated that some patients with locally advanced breast cancer benefit from placement of multiple radiographic markers around the tumor prior to initiating neoadjuvant chemotherapy because the newer chemotherapy regimens have become so effective at shrinking aggressive locally advanced breast cancers that surgeons are faced with performing lumpectomies on patients with no clinically or radiographically detectable breast cancer. The commenters stated further that while, in many cases, residual calcifications combined with the initial marker placed at the time of the needle biopsy are sufficient for localization, in some cases, it is necessary to delineate the extent of the primary tumor using several percutaneously placed markers. The commenters indicated that, in these cases, the markers are placed after the initial breast biopsy but months before the patient's definitive surgery.

Response: After further analysis, we agree that it is appropriate to pay separately for the placement of CPT code 19295 (Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)) when it is not reported on a claim with any other separately paid procedure with a status indicator of "S," "T," "V," or "X." This makes CPT code 19295 an "STVX-packaged code." As already discussed, an "STVX-packaged code" describes a HCPCS code whose payment is packaged when one or more separately paid primary services with the status indicator of "S," "T," "V," or "X" are furnished in the hospital outpatient encounter. We are convinced by the clinical scenarios provided by the commenter that it is appropriate for a metallic localization clip to be inserted at some point significantly prior to the procedure for which the localization is needed. Therefore, separate payment for the performance of the procedure

described by CPT code 19295 will be made in those circumstances when the hospital does not report another separately paid procedure with a status indicator of "S," "T," "V," or "X" on the same claim. CPT code 19295 is used to report the placement of a radiographic marker (not a wire exiting the skin, which has the potential for bleeding and infection).

However, we continue to believe that it remains appropriate to package payment for CPT codes 19290, 19291, 77031, 77032, and 76942 into the payment for the procedures of which these services are a part. CPT codes 19290 and 19291 may be used to report the placement of external wires, which, the commenters note, carry a risk of bleeding and infection, and, therefore, they are not appropriately performed on a different date than the primary procedure of which they are a part. With regard to CPT code 76942, the clinical scenario the commenters presented does not apply to this code, and the commenters did not present an additional clinical scenario to support the need to pay separately for this service. In addition, while hospitals reported CPT codes 77031 and 77032 on claims without any other procedure with a status indicator of "S," "T," "V," or "X" approximately 21 percent and 20 percent of time, respectively, the definitions of the codes do not fit the clinical scenarios for which the commenters presented convincing arguments, and the commenters presented no additional clinical scenarios that supported separate payment for these codes. For these reasons, we believe that it is inappropriate to make separate payment that may encourage hospitals to furnish CPT codes 19290, 19291, 77031, 77032, and 76942 without also providing the primary service.

After considering the APC Panel's recommendation and the public comments we received on this issue, we believe that it is appropriate to pay separately for CPT code 19295 when it is not furnished on the same date as a procedure that is separately paid and, therefore, we have assigned it a status indicator of "Q1" (packaged when reported with a procedure with a status indicator of "S," "T," "V," or "X"; otherwise separately paid), and have assigned CPT code 19295 to APC 0340 (Minor Ancillary Procedures), for which the median cost for CY 2011 is $48.72. We chose APC 0340 because, in the absence of cost data for the service for CY 2011, we believe that the resources required to furnish the service are most similar to the resources required to furnish other separately paid minor ancillary services. However, we continue to believe that payment for CPT codes 19290, 19291, 77031, 77032, and 76942 should be made as part of the payment for the procedures with which these codes are reported and, therefore, for CY 2011, we are retaining the status indicator of "N" for these codes.

Recommendation 4

In the CY 2011 OPPS/ASC proposed rule (75 FR 46224), we indicated that we were accepting the APC Panel's recommendation to continue to encourage submission of common clinical scenarios involving currently packaged HCPCS codes to the Packaging Subcommittee for its ongoing review. We also encouraged recommendations from the public on specific services or procedures whose payment would be most appropriately packaged under the OPPS. Additional detailed suggestions for the Packaging Subcommittee could be submitted by e-mail to *APCPanel@cms.hhs.gov* with Packaging Subcommittee in the subject line.

Recommendation 5

In the CY 2011 OPPS/ASC proposed rule (75 FR 46224), we indicated that we were accepting the APC Panel's recommendation that CMS provide information to the APC Panel on the impact of the creation of the imaging composite APCs on services to beneficiaries. We will present information on the impact of the imaging composites to the APC Panel at its winter CY 2011 meeting. Information on the impact of the creation of the imaging composites and our proposal with regard to the imaging composite APCs was discussed in detail in section II.A.2.e.(5) of the proposed rule. Our discussion of the imaging composite APCs is contained in section II.A.2.e.(5) of this final rule with public comment period.

Recommendation 6

The Packaging Subcommittee of the APC Panel was established to review packaging issues. In the CY 2011 OPPS/ASC proposed rule (75 FR 46224), we indicated that we were accepting the APC Panel's recommendation that the Packaging Subcommittee remain active until the next APC Panel meeting. That meeting occurred on August 23–24, 2010, and resulted in a recommendation to broaden the function of the Packaging Subcommittee and revise its name to Subcommittee for APC Groups and Status Indicator (SI) Assignments. We refer readers to our discussion of Recommendation 4 in section II.A.3.b.(2) of this final rule with comment period.

(3) Packaged Services Addressed by the August 2010 APC Panel Recommendations and Other Issues Raised in Public Comments

The APC Panel met again on August 23–24, 2010 to hear public presentations on the proposals set forth in the CY 2011 OPPS/ASC proposed rule. The APC Panel's Packaging Subcommittee reviewed the packaging status of several CPT codes and reported its findings to the APC Panel. The full report of the August 23–24, 2010 APC Panel meeting can be found on the CMS Web site at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp.* The APC Panel accepted the report of the Packaging Subcommittee, heard several presentations related to packaged services, discussed the deliberations of the Packaging Subcommittee, and made the following eight recommendations:

1. The Panel recommends that Current Procedural Terminology (CPT) code 31627, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s]*), continue to be assigned a status indicator of "N."

2. The Panel recommends that CMS provide claims data at the Panel's winter 2012 meeting about CPT code 31627, *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s]*), for the Panel's consideration.

3. The Panel recommends that CMS assign CPT 0191T, *Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, to APC 0673, Level V Anterior Segment Eye Procedures*, on the basis of its clinical similarity with both CPT 0192T, *Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach,* and HCPCS code 66180, *Aqueous shunt to extraocular reservoir (e.g., Molteno, Schocket, Denver-Krupin*).

4. The Panel recommends that the Packaging Subcommittee be renamed the Subcommittee for APC Groups and Status Indicator (SI) Assignments.

5. The Panel requests that CMS provide data for all unconditionally packaged items and services that appear by themselves on separate bills in outpatient claims data to the Subcommittee for APC Groups and SI Assignments.

6. The Panel encourages the public to submit common clinical scenarios

involving currently packaged HCPCS codes and recommendations of specific services or procedures for which payment would be most appropriately packaged under the Outpatient Prospective Payment System (OPPS) for review by the Subcommittee for APC Groups and Status Indicator (SI) Assignments.

7. The Panel recommends that Judith Kelly, R.H.I.T., R.H.I.A., C.C.S., be named chair of the Subcommittee for APC Groups and SI Assignments.

8. The Panel recommends that the work of the Subcommittee for APC Groups and Status Indicator (SI) Assignments continue.

Our response to the APC Panel's recommendations resulting from its August 23–24, 2010 public meeting, a summary of the public comments we received on the proposed rule for related topics, and our responses to those public comments follow:

Recommendation 1—Packaged Status of CPT Code 31627 (Electromagnetic Navigational Bronchoscopy (ENB))

Comment: Commenters asked that CMS pay separately for ENB and that CMS assign it to APC 0415 with a status indicator of "T". Another commenter asked that CMS create a composite APC for ENB that would establish a separate payment when ENB is performed on the same date as CPT codes 31625 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites), 31626 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple), 31628 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe), or 31629 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)). The commenters believed that such a composite APC would ensure that the payment would include the full costs of the bronchoscopy and the service described by CPT code 31627.

One commenter stated that it is inconsistent for CMS to package payment for ENB when CMS pays separately for services that are very similar. The commenter described in detail how ENB is most clinically similar to CPT code 31636 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus), which is separately paid under the OPPS. The commenter further stated that both procedures use a computer for registration and use a bronchoscope to facilitate access for either a guide wire or catheter. In both procedures, once the guide wire or catheter is in place, then either a stent or a fiducial marker is placed. In addition, the commenter noted that CPT code 19103 (Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance) is not packaged, notwithstanding that it uses imaging to guide the needle to the lesion for biopsy and is similar to ENB where the previously obtained CT scan is used to plan the pathway to the lung lesion and then the ENB catheter is used to reach the lesion for biopsy. The commenter stated that ENB is different from the other computer-assisted navigational procedures that CMS has packaged because, for example, those procedures use a computer only to assist with coordinate determination (for example, CPT 61795 (Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (List separately in addition to code for primary procedure)) or anatomy determination (for example, CPT code 20985 (Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)) but do not describe the steering of a catheter through an airway of the lung for the purpose of a biopsy or treatment. The commenter disagreed with the APC Panel that CPT code 31620 (Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure)) is a comparable procedure because they stated that ENB, unlike EBUS, does not produce an image, is not an ancillary procedure and does not enable a biopsy or placement of a marker for radiation therapy. The commenter believed that the definition of CPT code 31627 as an add-on code that can only be correctly reported with a primary procedure, does not justify packaging payment for the code into the payment for the primary procedure with which it is furnished because CMS routinely pays separately for add-on codes.

Several commenters noted that physicians are reimbursed for both the bronchoscopy and CPT code 31627 when they perform both and that several physician organizations support that separate payment should be made for CPT code 31627. Commenters also disagreed that payment for the primary service would reflect the cost of the packaged ENB procedure because they believed that a study performed in 2005 found the cost of ENB to be approximately $2,700 but the payment for bronchoscopy is much less than $2,700. Other commenters believed that packaging ENB violates the 2 times rule because CMS proposed to package ENB under a standard bronchoscopy procedure which is reimbursed under APC 0076 with a proposed payment of $719.84, although they believed that ENB costs $2,875.50, which is more than two times the highest median in APC 0076 (CPT code 31899 (Unlisted procedure, trachea, bronchi) at $1,247.56). In addition, the commenter stated that all Medicare Administrative Contractor medical directors are covering and making payment for ENB. In addition, the commenters stated that Administrative Law Judges have, on multiple occasions, overturned denials of separate payment for ENB and have ordered CMS to pay for ENB in addition to standard bronchoscopy. In addition, the commenter stated that all Medicare Administrative Contractor (MAC) Medicare Directors are covering and making payment for ENB.

Response: For the CY 2011 OPPS, we proposed to continue to package the payment for ENB into the payment for the bronchoscopy to which we believe that it is ancillary and supportive (75 FR 46223). The APC Panel met on August 23–24, 2010, to discuss the CMS proposed rule and recommended that CMS continue to package payment for CPT code 31627 into payment for the procedure with which it is performed and asked that CMS bring claims data on the cost of CPT code 31627 to the APC Panel's winter 2011 meeting for review. The full set of APC Panel recommendations that resulted from the Panel's August 23–24, 2010 meeting is provided in this section.

After consideration of all of the information provided by commenters on this issue, and discussing the issue with the APC Panel at its August 23–24, 2010 meeting, we are accepting the APC Panel's Recommendation 1 to continue to package payment for CPT code 31627 into the payment for the major separately paid procedure with which it is reported for CY 2011. In addition, we are accepting the APC Panel's Recommendation 2, discussed below, that CMS bring claims data to the winter 2011 APC Panel meeting.

We continue to believe that packaging payment for ENB into payment for the procedure in which it is furnished is appropriate because CPT code 31627

describes the computer assisted image guided navigation that is reported in addition to a specified range of bronchoscopy codes. As such, we believe that it is an ancillary and dependent service that enhances and supplements another service. The CPT code does not describe an independent service that can be reported alone.

We do not believe that CPT code 31627 describes a service that is similar to the services described by CPT code 31636 or 19103 because CPT code 31627 is neither for placement of a stent (CPT code 31636) nor for a biopsy (CPT code 19103). Similarly, we do not agree that ENB is significantly different from the services described by CPT codes 61795 and 20985 and from EBUS. The commenter stated that these navigation codes are unlike ENB (CPT code 31627 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])) because ENB requires steering a catheter through an airway of the lung for the purpose of a biopsy or treatment. While a catheter may be used to accomplish localization of the target during the ENB procedure, when the services described by CPT codes 61795 and 20985 are utilized, another method of localization of the target is utilized. For example, when CPT code 20985 (Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)) is performed, an infra-red, electromagnetic or other form of tracker may be utilized for localization of the target. Like CPT codes 61795 and 20985, ENB is an add-on code that adds computer-assisted navigation to the primary procedure, which, in the case of ENB, is a bronchoscopy.

We believe that ENB is an enhancement to the bronchoscopy with which it must be performed and as such is an ancillary and dependent service in the same manner that CPT code 31620 (EBUS) is an ancillary and supportive procedure. Both of these procedures enable the bronchoscopy with which they are performed to be more effective. We agree with the APC Panel that EBUS is the most suitable comparison because it describes another bronchoscopic procedure in which a guidance technology (that is, ultrasonography) is used to achieve the therapeutic benefit of the procedure. Similar to our proposed payment for CPT code 31627, payment for CPT code 31620 is currently packaged into the primary modality with which it would be appropriately billed. In CY 2008, as part of our increased packaging proposal, we identified the EBUS procedure as an intraoperative ancillary service that would typically be reported in conjunction with an independent service. In addition, similar to CPT code 31627, CPT code 31620 would only be appropriately reported in conjunction with specified bronchoscopy procedures with which it would be performed. Like EBUS, CPT code 31627, ENB is not an independent separately furnished procedure.

We agree that the status of CPT code 31627 as an add-on code does not, of its own accord, justify packaged payment for the service as is evidenced, as the commenter noted, by separate payment under the OPPS for many add-on services. However, the status of the code as an add-on code supports the view that the procedure is a service that is always furnished in addition to another procedure and cannot be performed independently. We recognize that the Medicare Physician Fee Schedule (MPFS) pays separately for CPT code 31627, as it does for all add-on codes, but the MPFS and the OPPS are very different payment systems. Each is established under a different set of statutory and regulatory principles and the policies established under the physician fee schedule do not have bearing on the payment policies under the OPPS. With regard to the commenter's view that the costs of ENB cannot be packaged into payment for a bronchoscopy because a study shows the cost of ENB to be $2,700 or $2,875.50, depending on the commenter, while the proposed payment CMS proposed for CY 2011 for a bronchoscopy assigned to APC 0076 is $719.84, we note that we will develop, analyze, and provide to the APC Panel at its winter 2011 meeting, the cost and frequency data we derive from the CY 2010 claims for CPT code 31627 for purposes of illuminating consideration of whether the costs of ENB are being reflected in the claims for the service with which they are furnished. With regard to making a composite APC for ENB that would establish a separate payment for ENB when it is performed on the same date as the services that are reported using CPT code 31625, 31626, 31628 or 31629, it is unclear whether ENB is a good candidate for a composite APC because composite APCs usually make payment for two separately paid procedures that are commonly performed together, and CPT code 31627 is currently a packaged service.

With regard to the comment that packaging ENB is a violation of the 2 times rule, we note that a 2 times rule violation can exist only within an APC and ENB has not been assigned to an APC because it is packaged and hence there is no application of the 2 times rule. We refer readers to section III. B. of this final rule with comment period for a more complete discussion of the 2 times rule.

With regard to the argument that CMS should pay separately for ENB because MAC medical directors cover it and may have made separate payment for it, and that Administrative Law Judges may have overturned denials of separate payment for ENB is not relevant to whether the payment for it should be packaged into the payment for the bronchoscopy to which it is ancillary and supportive.

After consideration of the public comments we received on this issue and the APC Panel's August 2010 recommendation on ENB, we are packaging payment for the service represented by CPT code 31627 into payment for the procedure with which it is performed for the CY 2011 OPPS.

Recommendation 2—Developing and Sharing Cost Data for ENB

We accept the APC Panel's recommendation to provide cost data on ENB, and we will provide the APC Panel with cost and frequency data at the winter 2011 APC Panel meeting for the Panel's use in providing CMS with a recommendation for CY 2012.

Recommendation 3—APC Assignment for CPT Code 0192T

We are accepting the APC Panel's recommendation. We refer readers to section III.D. of this final rule with comment period for a discussion of CPT code 0192T.

Recommendation 4—Name and Function of the Packaging Subcommittee

We agree with the APC Panel's recommendation and have changed the name and function of the committee to include the assessment of the content of APCs as well as the appropriate status indicator for each CPT code, including but not limited to the decision of whether, and if so when, to package payment for the service into payment for the services with which it is furnished. The Packaging Subcommittee will be renamed the "Subcommittee for APC Groups and Status Indicator (SI) Assignments."

Recommendation 5

We agree and will, at the winter 2011 APC Panel meeting, furnish data about the frequency with which hospitals report unconditionally packaged HCPCS

codes on claims without another separately paid procedure.

Recommendation 6

We support the APC Panel's recommendation that the public submit common clinical scenarios involving currently packaged HCPCS codes and make recommendations of specific services or procedures for which payment would be most appropriately packaged under the OPPS for review by the Subcommittee for APC Groups and Status Indicator (SI) Assignments.

Recommendation 7—Chair of the Subcommittee for APC Groups and Status Indicator (SI) Assignments

We are accepting the APC Panel's recommendation that Judith Kelly, R.H.I.T., R.H.I.A., C.C.S., be named chair of the Subcommittee for APC Groups and Status Indicator (SI) Assignment.

Recommendation 8

We are accepting the APC Panel's recommendation that the work of the Subcommittee for APC Groups and Status Indicator (SI) Assignments continue. We are continuing the work of the APC Panel Subcommittee for APC Groups and Status Indicator (SI) Assignments, and we appreciate the Subcommitee's expertise and experience regarding packaging under the OPPS and the valuable advice the Subcommittee continues to provide to us. We will continue to bring to the Subcommittee's attention clinical scenarios identified by us or the public regarding services that are currently packaged or are candidates for future packaging under the OPPS.

We received public comments in response to the proposed rule on several issues related to packaging of payment that were in addition to those about which the APC Panel has made a recommendation that are related to packaging payment for ancillary and dependent services into payment for services that may be furnished independently.

Comment: Commenters stated that CMS' packaging policies would likely lead to less efficient use of resources, limited access to innovative treatment options and greater instability in payments because the policies are based on several flawed assumptions. Commenters believed that to the extent that hospitals control the array of services they provide, CMS' packaging policies assume that the same incentives apply to hospital outpatient departments as to inpatient services. One commenter stated that under the inpatient prospective payment system (IPPS), hospitals have an incentive to provide care, including advanced technologies, in an efficient manner to ensure the lowest cost for the patient's diagnosis. In contrast, in hospital outpatient departments, because Medicare payment is based on procedures rather than diagnoses, the commenter believed that a hospital has an incentive to provide the lowest cost item or service included in an APC. The commenter further believed that if that service does not fully address the patient's needs, the hospital would receive better reimbursement by bringing the patient back for a second visit or admitting the patient for inpatient care than by providing a more costly option within the same APC. Moreover, the commenters believed that when an APC's payment rate is significantly less than the cost of a technology, hospitals have a strong disincentive to use that technology, even if it could reduce the costs of care at a later date. The commenters believed that CMS' use of expanded packaging has the risk of encouraging hospitals to forego performing needed services and using new technologies that may be more resource intensive during one visit, but could save the patient future outpatient department visits or inpatient care.

Response: Packaging payment for items and services that are ancillary to and dependent on the major procedure for which a payment rate is established is a fundamental concept of the OPPS, based in regulation in the definition of costs that are included in the national payment rate for a service (42 CFR 419.2(b)) and in place since the inception of the OPPS (65 FR 18447). We continue to believe that packaging creates incentives for hospitals and their physician partners to work together to establish appropriate protocols that eliminate unnecessary services where they exist and institutionalize approaches to providing necessary services more efficiently. With respect to new services or new applications of existing technology, we believe that packaging payment for ancillary and dependent services creates appropriate incentives for hospitals to seriously consider whether a new service or a new technology offers a benefit that is sufficient to justify the cost of the new service or technology. Where this review results in reductions in services that are only marginally beneficial or hospitals' choices not to utilize certain technologies, we believe that this could improve, rather than harm, the quality of care for Medicare beneficiaries because every service furnished in a hospital carries some level of risk to the patient. Moreover, we believe that hospitals strive to provide the best care they can to the patients they serve so that when new technologies are proven to improve the quality of care, their utilization will increase appropriately, whether the payment for them is packaged or not.

However, we are aware that there are financial pressures on hospitals that might motivate some providers to split services among different hospital encounters in such a way as to maximize payments. While we do not expect that hospitals would routinely change the way they furnish services or the way they bill for services in order to maximize payment, we recognize that it would be possible and we consider that possibility as we annually review hospital claims data. We will continue to examine claims data for patterns of fragmented care, and if we find a pattern in which a hospital appears to be dividing care across multiple days, we will refer it for investigation to the QIO or to the program safeguard contractor, as appropriate to the circumstances we find.

In section II.A.1. of this final rule with comment period, we discuss the established methodology we use to incorporate the costs of packaged services into payment for the associated independent procedures. We package the costs of services into the payment for the major separately paid procedure on the same claim on which the packaged service appears. Hence, it is the practice of hospitals with regard to reporting and charging for packaged services that determines the separately paid service into which the cost of a packaged service is incorporated and the amount of packaged cost included the payment for that separately paid procedure.

We believe it is important to continue to advance value-based purchasing by Medicare in the hospital outpatient setting by furthering the focus on value of care rather than volume. While we acknowledge the concerns of the commenters and, as discussed below, are committed to considering the impact of packaging payment on Medicare beneficiaries further in the future, we must balance the concerns of the commenters with our goal of continuing to encourage efficient use of hospital resources. As we noted in the CY 2009 OPPS/ASC final rule with comment period in our response to comments on the CY 2009 OPPS/ASC proposed rule (73 FR 68572) and as we note in our responses to public comments on the CY 2011 OPPS/ASC proposed rule, the suggestions and packaging criteria

recommended by most commenters are focused almost exclusively on preventing packaging, rather than on determining when packaging would be appropriate. We also welcome suggestions from the public on approaches to packaging that would encourage efficient use of hospital resources.

Comment: Commenters asked that CMS make underlying payment rates for packaged services, including utilization rates, estimated median costs and numbers of hospitals furnishing various services available to the public. Commenters also asked that CMS continue to compare utilization of services in 2007 prior to packaging to utilization of the same services after packaging at the CPT level and make that information public. In addition, commenters asked that CMS study and report annually on the impact of packaged payment on beneficiary access to care. Commenters urged CMS to continue to monitor use of and payment for these services and share these reports with stakeholders, so that they can verify that Medicare's payment policies do not harm access to care. Commenters stated that CMS should provide data that demonstrates that the full cost of packaged services is reflected in the median cost for the services in which they are used.

Response: As we note in our discussion above, we have reviewed the provision of packaged services for several years since we expanded packaging in CY 2008 and we see no evidence that increased packaging has caused harm to patient access to care, nor have we been presented with evidence that documents that packaging has been responsible for harm to patient access. Each year, CMS makes available an extensive amount of OPPS data that can be used for any data analysis an interested party would care to perform. Specifically, we make available a considerable amount of data for public analysis each year through the supporting data files that are posted on the CMS Web site in association with the display of the proposed and final rules. In addition, we make available the public use files of claims, including, for CY 2008 and later, supplemental line item cost data for every HCPCS code under the OPPS and a detailed narrative description of our data process for the annual OPPS/ASC proposed and final rules that the public can use to perform any desired analyses. Therefore, commenters are able to examine and analyze these data to develop specific information to assess the impact and effect of packaging for the services of interest to them. Therefore, this information is available to support their requests for changes to payments under the OPPS, whether with regard to separate payment for a packaged service or other issues. We understand that the OPPS is a complex payment system and that it may be difficult to determine the quantitative amount of packaged cost included in the median cost for every independent service. However, commenters routinely provide us with meaningful analyses at a very detailed and service-specific level based on the claims data we make available. We routinely receive complex and detailed public comments including extensive code-specific data analysis on packaged and separately paid codes, using the data from this and prior proposed and final rules. With respect to the request for assurance that the full cost of packaged services is included in the median cost used to set the payment rate for the independent service with which the packaged services are reported, we note that the use of a median cost as the measure of central tendency means that the full cost of a packaged service becomes part of the cost of the service with which it is furnished and is reflected in the median cost for the independent procedure since the median cost reflects the cost at the 50th percentile of the array of the total costs for all claims in the set of single bills used to calculate the median cost for the CPT code or the APC.

Comment: Commenters stated that, for packaged services such as guidance, image processing, and intraoperative services, CMS should provide separate, additional payment for innovative procedures. They urged CMS establish a 2- to 3-year data collection period during which separate payment would be made for these packaged services (or any new applications of these services). The commenters stated that the data collected during this period should be used to evaluate the clinical utilization and financial effects of the new services and that CMS should use this information to determine whether to propose packaging for the services or whether to maintain separate payment. They further stated that hospitals are reluctant to invest in new technologies because they are uncertain whether they will be able to recoup the cost of the services and that packaging payment for new technologies into payment for existing major separately paid procedures discourages them from making the investment.

Response: We do not agree that innovative guidance, image processing, and intraoperative services or innovative uses of guidance, image processing, and intraoperative services should always be separately paid for a 2- to 3-year data collection period before a decision to make separate or packaged payment for them. We do not believe that making separate payment for 2 to 3 years would create incentives for hospitals to carefully consider whether the innovative service or innovative use of a pre-existing service represents sufficient value to be worthy of the investment. We continue to believe that hospitals will invest in innovative services or services with innovative uses where these services represent genuinely increased value to patient care, and where hospitals can furnish them efficiently. Of course, we will continue to pay separately for innovative technologies where a device meets the conditions for separate payment as a pass-through device or where a new procedure meets the criteria for payment as a new technology APC.

Comment: Commenters believed that CMS assumes that its packaging policies will allow it to continue to collect the data it needs to set appropriate, stable payment rates in the future. The commenters believed that CMS' review of data from 2009 indicates that hospitals have continued to report codes for packaged services, but they stated that it remains to be seen if hospitals will continue this practice in subsequent years, particularly for services that have been packaged since their introduction. Commenters further stated that CMS' past experience with packaging payment for ancillary items indicates that hospitals do not submit codes for services that do not directly affect their payment and see no reason to believe that this will change and ask that CMS require complete and correct coding for packaged services so that all items and services that are not individually reimbursed must be included on the claim to provide CMS with essential data for future OPPS updates. Commenters expressed concern about what they believed to be decreases in the number of hospitals reporting services as a result of packaging and bundling. They believed that the decline could be due to one or both of two reasons: Hospitals may no longer be providing these services or hospitals could be providing these services but not reporting codes and charges for them, denying CMS accurate data for use in ratesetting. The commenters were concerned that decreased reporting of services will result in the costs of packaged services not being included in the payment for the independent service with which they are furnished.

Response: We do not believe that there has been or will be a significant change in what hospitals report and charge for the outpatient services they furnish to Medicare beneficiaries and other patients as a result of our current packaging methodology. Medicare cost reporting standards specify that hospitals must impose the same charges for Medicare patients as for other patients. We are often told by hospitals that many private payers pay based on a percentage of charges and that, in accordance with Medicare cost reporting rules and generally accepted accounting principles, hospital chargemasters do not differentiate between the charges to Medicare patients and other patients. Therefore, we have no reason to believe that hospitals will stop reporting HCPCS codes and charges for packaged services they provide to Medicare beneficiaries. As we stated in the CY 2009 OPPS/ASC final rule with comment period (74 FR 68575), we strongly encourage hospitals to report a charge for each packaged service they furnish, either by billing the packaged HCPCS code and a charge for that service if separate reporting is consistent with CPT and CMS instructions, by increasing the charge for the separately paid associated service to include the charge for the packaged service, or by reporting the charge for the packaged service with an appropriate revenue code but without a HCPCS code. Any of these means of charging for the packaged service will result in the cost of the packaged service being incorporated into the cost we estimate for the separately paid service. If a HCPCS code is not reported when a packaged service is provided, we acknowledge that it can be challenging to specifically track the utilization patterns and resource cost of the packaged service itself. However, we have no reason to believe that hospitals have not considered the cost of the packaged service in reporting charges for the independent, separately paid service.

We expect that hospitals, as other prudent businesses, have a quality review process that ensures that they accurately and completely report the services they furnish, with appropriate charges for those services to Medicare and all other payers. We encourage hospitals to report on their claim for payment all HCPCS codes that describe packaged services that were furnished, unless the CPT Editorial Panel or CMS provides other guidance. To the extent that hospitals include separate charges for packaged services on their claims, the estimated costs of those packaged services are then added to the costs of separately paid procedures on the same claims and used in establishing payment rates for the separately paid services.

It is impossible to know with any certainty whether hospitals are failing to report HCPCS codes and charges for services for which the payment is packaged into payment for the independent service with which the packaged service is furnished. Moreover, where hospitals fail to report the HCPCS codes and charges for packaged services, the reason may be that the hospital has chosen to package the charge for the ancillary and dependent service into the charge for the service with which it is furnished. Although we prefer that hospitals report HCPCS codes and charges for all services they furnish, if the hospital's charge for the independent service also reflects the charge for all ancillary and supportive services it typically provides, the absence of HCPCS codes and separate charges would not result in inappropriately low median cost for the independent service, although CMS would not know which specific ancillary and supportive services were being furnished. Where a hospital is no longer providing a service, there may be many reasons that a hospital chooses not to provide a particular service or chooses to cease providing a particular service, including, but not limited to, because the hospital has determined that it is no longer cost effective for the hospital to furnish the service and that there may be other hospitals in the community that can furnish the service more efficiently.

Comment: Many commenters who objected to payment for ancillary and dependent services being packaged into payment for the procedures that they support said that packaged payment will cause hospitals not to make these important services available to Medicare beneficiaries because they are not being paid separately for them by Medicare.

Response: We do not believe that hospitals will cease to furnish Medicare beneficiaries with the ancillary and dependent services that are available in the facility when they are necessary to achieve the best therapeutic effect for their patients because the payment for the service is made as part of the payment for the procedure that they support. Instead, we believe that packaging will encourage hospitals to carefully review whether the ancillary and dependent services are genuinely necessary in individual cases to all patients and will carefully evaluate whether the staff and capital investments that are often necessary to furnish them are worthwhile. We note also that hospitals that fail to provide Medicare beneficiaries with the same services that they make available to other patients with the same conditions are subject to termination from the Medicare program under 42 CFR 489.53(a)(2). Therefore, hospitals have a significant disincentive to treat Medicare patients differently from other patients with regard to the nature and scope of the services they furnish them.

Comment: One commenter stated that CMS should provide further transparency and clarification of its analysis of image processing procedures because it is not clear why CMS has discussed coding issues pertaining to intraoperative procedures to support conclusions about packaging of image processing procedures. Specifically, the commenter stated that CMS notes that the intraoperative procedures described by CPT codes 93320 (which describes spectral Doppler) and 93325 (which describes color flow Doppler) are now reported using one comprehensive code, CPT 93306, which describes complete transthoracic echocardiogram with spectral and color flow Doppler. The commenter further reiterated CMS' statements that when data for any codes experiencing significant modifications were removed, there was a 7 percent decrease from CY 2007 to CY 2009 in the frequency of image processing services billed. In a second analysis involving all image processing services, including those with revised codes, the data showed a 61-percent decrease in the billing of these services between CY 2007 and CY 2009 and a 6-percent decrease in the number of hospitals reporting these services during the same timeframe. The commenter believed the estimated declines in utilization of imaging processing services should not simply be disregarded, but in fact may suggest negative impacts on beneficiary access to these services.

Response: The example we provided was not optimal and we were incorrect to characterize both CPT codes 93320 and 93325 as intraoperative services. For purposes of our analysis, we treated CPT code 93320 as an intraoperative service and we treated CPT code 93325 as an imaging processing service. The point of the example is that because both codes are reported using CPT code 93306, effective for services on and after January 1, 2009, the CY 2009 data for these codes (93320 and 93325) cannot be compared to the data for them in CY 2007 in a meaningful way and for that reason we believe that the decreases we found are suspect.

(4) Other Service-Specific Packaging Issues

We received the following public comments regarding the proposal to package specific services or services in a specific category.

Comment: Commenters recommended that CMS eliminate packaging of IGRT services represented by CPT codes 76950 (Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation), 76965 (Ultrasonic guidance for interstitial radioelement application), 77417 (Therapeutic radiology port film(s)), 77421 (Stereoscopic X ray guidance for localization of target volume for the delivery of radiation therapy), and 77014 (Computed tomography guidance for placement of radiation fields) for CY 2011. The commenters believed that if packaging is continued, closer monitoring of the claims data is necessary to better approximate the real costs associated with these services. They believed that these services are vital to the safe provision of radiation therapy, and unconditionally packaging payment for them may discourage hospitals from providing them. The commenters also believed that hospitals may not be reporting the services correctly and, therefore, not charging for them, which would lead to the cost of the service not being reflected into the packaged payment for the service for which separate payment is made.

Response: We continue to believe that these services are ancillary and dependent services that, as the commenters indicated, are fundamental to the provision of optimal radiation therapy services and that the payment for them should be packaged into the payment for the procedure to which they are ancillary and supportive. We agree that it is vital that hospitals ensure that they report the charges for these services so that the cost of the independent service reflects the cost of these important ancillary services. We strongly encourage hospitals to report both the codes and the charges for these services, recognizing that some hospitals may prefer to incorporate the charge for the ancillary service into the charge for the service it supports. We remind hospitals that the payments they receive are developed from the charges they submit on claims and the charge and costs they report on their Medicare cost report. Therefore, it behooves them to ensure that they are fully reporting the charges on the claims they submit for payment. Moreover, we do not believe that there is value in closer monitoring of claims data for the purpose of better approximation of the real costs associated with ancillary and dependent services because we believe that our standard data process ensures that, to the extent that hospitals report charges for these services, whether with separate HCPCS codes or as part of the charge for the procedure to which they are ancillary and supportive, the cost of the service will be included in the APC median cost and, therefore, in the payment for the APC to which the separately paid procedure is assigned.

Comment: One commenter was concerned that intravascular ultrasound and intracardiac echocardiography services are relatively high cost and low frequency services and, therefore, a small proportion of their cost is reflected in the payments for the services with which they are used. Although the commenter recognized that CMS found increases in reporting of these codes and payment for the procedures into which they are packaged from CY 2007 to CY 2009, the commenter continued to be concerned that payment is not adequate to protect access to these services and asked that CMS reinstate separate payment for intravascular ultrasound and intracardiac echocardiography services.

Response: We note that IVUS, ICE, and FFR services are existing, established, technologies and that hospitals have provided some of these services in the HOPD since the implementation of the OPPS in CY 2000. IVUS, FFR, and ICE are all dependent services that are always provided in association with independent services. Given the sizable increase in the number of services furnished and the associated payment between CY 2007 and CY 2009, as demonstrated by the analysis we presented in the proposed rule and recapped earlier in this section, we have seen no evidence from our claims data that beneficiary access to care is being harmed by packaging payment for IVUS, ICE, and FFR services or that payment is inadequate for hospitals to be able to afford to furnish these services with their associated independent services. We believe that packaging creates appropriate incentives for hospitals and their physician partners to carefully consider the technologies that are used in the care of patients in order to ensure that technologies are selected for use in each case based on their expected benefit to a particular Medicare beneficiary.

Comment: Some commenters recommended that if the existing policy to package payment for nonpass-through implantable biologicals were to continue, CMS develop a crosswalk that includes specific procedure codes for nonpass-through implantable biologicals so that procedures involving those products could be reassigned to new APCs. The commenters also recommended that CMS provide an in-depth analysis of the packaging methodology to ensure that the costs of nonpass-through implantable biologicals are included in the procedural APCs.

Response: We believe that creating and maintaining a crosswalk of nonpass-through implantable biological HCPCS codes and associated procedure codes would not be feasible because implantable biologicals may be used in a wide variety of surgical procedures. We also do not believe that it is necessary to develop such a crosswalk to ensure that the costs of nonpass-through implantable biologicals are included in the APC payment rates. As we discuss in section II.A.3. of this final rule with comment period, hospitals include HCPCS codes and charges for packaged services on their claims. Our packaging methodology ensures that the estimated costs associated with those packaged services are added to the costs of separately payable procedures on the same claims in establishing payment rates for the separately payable services.

Regarding the request for in-depth data analysis, we note that each year CMS makes available an extraordinary amount of OPPS data that can be used for any data analysis an interested party would care to perform. Specifically, we make available a considerable amount of data for public analysis each year through the supporting data files that are posted on the CMS Web site in association with the display of the proposed and final rules. In addition, we make available the public use files of claims, including, for CY 2008 and later, supplemental line item cost data for every HCPCS code under the OPPS and a detailed narrative description of our data process for the annual OPPS/ASC proposed and final rules that the public can use to perform any desired analyses. Therefore, commenters are able to examine and analyze these data to develop specific information to assess the impact and effect of packaging for the services of interest to them or to support their requests for changes to payments under the OPPS, whether with regard to separate payment for a packaged service or other issues. We understand that the OPPS is a complex payment system and that it may be difficult to determine the quantitative amount of packaged cost included in the median cost for every independent service. However, commenters routinely provide us with meaningful analyses at a very detailed and service-specific level

based on the claims data we make available. We routinely receive complex and detailed public comments including extensive code-specific data analysis on packaged and separately paid codes, using the data from this and prior proposed and final rules.

Comment: One commenter objected to CMS' policy of packaging payment for tositumomab into HCPCS code G3001 (Administration and supply of tositumomab, 450 mg) and requested that CMS create a HCPCS J-code for tositumomab, which is currently provided under a radioimmunotherapy regiment and billed as part of HCPCS code G3001. The commenter argued that because tositumomab is listed in compendia, is approved by the FDA as part of the BEXXAR® regimen, and has its own National Drug Code (NDC) number, it should be recognized as a drug and, therefore, be paid as other drugs are paid under the OPPS methodology, instead of having a payment rate determined by hospital claims data. The commenter suggested that a payment rate could be established using the ASP methodology.

Response: As we stated in the CY 2010 OPPS/ASC final rule with comment period (75 FR 60517), we have consistently noted that unlabeled tositumomab is not approved as either a drug or a radiopharmaceutical, but it is a supply that is required as part of the radioimmunotherapy treatment regiment (CY 2009 OPPS/ASC final rule with comment period (73 FR 68658); CY 2008 OPPS/ASC final rule with comment period (72 FR 66765); CY 2006 OPPS final rule with comment period (70 FR 68654); and CY 2004 OPPS final rule with comment period (68 FR 63443)). We do not make separate payment for supplies used in services provided under the OPPS. Payments for necessary supplies are packaged into payment for the separately payable services provided by the hospital. Specifically, administration of unlabeled tostitumomab is a complete service that qualifies for separate payment under its own clinical APC. This complete service is currently described by HCPCS code G3001. Therefore, we do not agree with the commenter's recommendation that we assign a separate HCPCS code to the supply of unlabeled tositumomab. Rather, we will continue to make separate payment for the administration of tositumomab while payment for the supply of unlabeled tostitumomab will continue to be packaged into the administration payment.

In addition to our final policies for specific packaged services, we will continue to package payment for the services we identified with a status indicator of "N" in Addendum B of the proposed rule with public comment into the payment for the separately paid procedures with which they are reported on a claim. We refer readers to section V.B.2.d. of this final rule with comment period for further discussion of our final policy to package payment for contrast agents and diagnostic radiopharmaceuticals. We refer readers to section II.A.2.e.(1) of this final rule with comment period for further discussion of our final policy to pay for observation services through extended assessment and management composite APCs under certain circumstances.

4. Calculation of OPPS Scaled Payment Weights

As we proposed in the CY 2011 OPPS/ASC proposed rule (75 FR 46224 through 46225), using the APC median costs discussed in sections II.A.1. and II.A.2. of this final rule with comment period, we calculated the final relative payment weights for each APC for CY 2011 shown in Addenda A and B to this final rule with comment period. In years prior to CY 2007, we standardized all the relative payment weights to APC 0601 (Mid Level Clinic Visit) because mid-level clinic visits were among the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC.

Beginning with the CY 2007 OPPS (71 FR 67990), we standardized all of the relative payment weights to APC 0606 (Level 3 Clinic Visits) because we deleted APC 0601 as part of the reconfiguration of the clinic visit APCs. We selected APC 0606 as the base because APC 0606 was the mid-level clinic visit APC (that is, Level 3 of five levels). Therefore, in the CY 2011 OPPS/ASC proposed rule (75 FR 46225), for CY 2011, to maintain consistency in using a median for calculating unscaled weights representing the median cost of some of the most frequently provided services, we proposed to continue to use the median cost of the mid-level clinic visit APC (APC 0606) to calculate unscaled weights. Following our standard methodology, but using the proposed CY 2011 median cost for APC 0606, for CY 2011 we assigned APC 0606 a relative payment weight of 1.00 and divided the median cost of each APC by the proposed median cost for APC 0606 to derive the proposed unscaled relative payment weight for each APC. The choice of the APC on which to base the proposed relative weights for all other APCs does not affect the payments made under the OPPS because we scale the weights for budget neutrality.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a budget neutral manner. Budget neutrality ensures that the estimated aggregate weight under the OPPS for CY 2011 is neither greater than nor less than the estimated aggregate weight that would have been made without the changes. To comply with this requirement concerning the APC changes, we proposed to compare the estimated aggregate weight using the CY 2010 scaled relative weights to the estimated aggregate weight using the proposed CY 2011 unscaled relative weights. For CY 2010, we multiplied the CY 2010 scaled APC relative weight applicable to a service paid under the OPPS by the volume of that service from CY 2009 claims to calculate the total weight for each service. We then added together the total weight for each of these services in order to calculate an estimated aggregate weight for the year. For CY 2011, we performed the same process using the proposed CY 2011 unscaled weights rather than scaled weights. We then calculated the weight scaler by dividing the CY 2010 estimated aggregate weight by the proposed CY 2011 estimated aggregate weight. The service-mix is the same in the current and prospective years because we use the same set of claims for service volume in calculating the aggregate weight for each year. For a detailed discussion of the weight scaler calculation, we refer readers to the OPPS claims accounting document available on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/*. We included payments to CMHCs in our comparison of estimated unscaled weight in CY 2011 to estimated total weight in CY 2010 using CY 2009 claims data, holding all other components of the payment system constant to isolate changes in total weight. Based on this comparison, we adjusted the unscaled relative weights for purposes of budget neutrality. The proposed CY 2011 unscaled relative payment weights were adjusted by multiplying them by a proposed weight scaler of 1.3650 to ensure budget neutrality of the proposed CY 2011 relative weights.

Section 1833(t)(14) of the Act provides the payment rates for certain "specified covered outpatient drugs." That section states that "Additional expenditures resulting from this paragraph shall not be taken into

account in establishing the conversion factor, weighting and other adjustment factors for 2004 and 2005 under paragraph (9) but shall be taken into account for subsequent years." Therefore, the cost of those specified covered outpatient drugs (as discussed in section V.B.3. of the proposed rule and this final rule with comment period) was included in the proposed budget neutrality calculations for the CY 2011 OPPS.

We did not receive any public comments on the proposed methodology for calculating scaled weights from the median costs for the CY 2011 OPPS. Therefore, for the reasons set forth in the proposed rule (75 FR 46224 and 46225), we are finalizing our proposed methodology without modification, including updating of the budget neutrality scaler for this final rule with comment period as we proposed. Under this methodology, the final unscaled payment weights were adjusted by a weight scaler of 1.4477 for this final rule with comment period. The final scaled relative payment weights listed in Addenda A and B to this final rule with comment period incorporate the recalibration adjustments discussed in sections II.A.1. and II.A.2. of this final rule with comment period.

B. Conversion Factor Update

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis by applying the OPD fee schedule increase factor. For CY 2011, for purposes of section 1833(t)(3)(C)(iv) of the Act, subject to sections 1833(t)(17) and (t)(3)(F), the OPD fee schedule increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act, which we refer to as the hospital market basket update, or simply the market basket, in this discussion.

The proposed hospital market basket increase for FY 2011 published in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24062) prior to changes required by the Affordable Care Act was 2.4 percent. New sections 1833(t)(3)(F)(iii) and 1833(t)(3)(G)(i) of the Act, as added by section 3401(i) of the Affordable Care Act and as amended by section 10319(g) of such Act and further amended by section 1105(e) of such Act, require a 0.25 percentage point reduction to the CY 2011 OPD fee schedule increase factor, which resulted in a proposed CY 2011 OPPS market basket update of 2.15 percent. The applicable percentage increase for FY 2011 published in the IPPS final rule on August 16, 2010, is 2.35 percent (75 FR 50352), which is the 2.6 percent market basket update, less the 0.25 percentage point reduction required by the Affordable Care Act. We announced the CY 2010 OPPS conversion factor of $67.241 in an OPPS/ASC notice (CMS 1504–N), issued in the **Federal Register** on August 3, 2010 (75 FR 45771). Hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) are subject to a reduction of 2.0 percentage points from the OPD fee schedule increase factor adjustment to the conversion factor. For a complete discussion of the HOP QDRP requirements and the payment reduction for hospitals that fail to meet those requirements, we refer readers to section XVI. of this final rule with comment period.

To set the OPPS conversion factor for CY 2011, we increased the CY 2010 conversion factor of $67.241 by 2.35 percent. In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for CY 2011 to ensure that any revisions we make to the updates for a revised wage index and rural adjustment are made on a budget neutral basis. We calculated an overall budget neutrality factor of 1.0009 for wage index changes by comparing total payments from our simulation model using the FY 2011 IPPS final wage indices to those payments using the current (FY 2010) IPPS wage indices, as adopted on a calendar year basis for the OPPS, as indicated in the August 3, 2010 OPPS/ASC **Federal Register** notice announcing Affordable Care Act changes to the wage indices (CMS–1504–N, 75 FR 45771). For CY 2011, as we proposed, we are not making a change to our rural adjustment policy. Therefore, the budget neutrality factor for the rural adjustment is 1.0000. For CY 2011, we are not finalizing a cancer hospital adjustment policy, as discussed in section II.G. of this final rule with comment period, and, therefore, would not have a budget neutrality adjustment for that policy.

For this final rule with comment period, we estimated that pass-through spending for both drugs and biologicals and devices for CY 2011 would equal approximately $57.7 million, which represents 0.15 percent of total projected CY 2011 OPPS spending. Therefore, the conversion factor was also adjusted by the difference between the 0.14 percent estimate of pass-through spending for CY 2010 and the 0.15 percent estimate of CY 2011 pass-through spending. Finally, estimated payments for outliers remain at 1.0 percent of total OPPS payments for CY 2011.

The OPD fee schedule increase factor of 2.35 percent for CY 2011 (that is, the CY 2011 estimate of the hospital market basket increase of 2.6 percent minus a 0.25 percentage point adjustment as required by the Affordable Care Act), the required wage index budget neutrality adjustment of approximately 1.0009, and the adjustment of 0.01 percent of projected OPPS spending for the difference in the pass-through spending resulted in a conversion factor for CY 2011 of $68.876, which reflects the full OPD fee schedule increase, after the adjustment required by the Affordable Care Act. To calculate the CY 2011 reduced market basket conversion factor for those hospitals that fail to meet the requirements of the HOP QDRP for the full CY 2011 payment update, we made all other adjustments discussed above, but used a reduced market basket increase update factor of 0.35 percent (that is, an unadjusted OPD fee schedule increase factor (market basket update) of 2.6 percent reduced by 0.25 percentage point as required by the Affordable Care Act and further reduced by 2.0 percentage points as required by section 1833(t)(17)(A)(i) of the Act for failure to comply with the OPD quality reporting requirements) . This resulted in a reduced conversion factor for CY 2011 of $67.530 for those hospitals that fail to meet the HOP QDRP requirements (a difference of −$1.346 in the conversion factor relative to those hospitals that met the HOP QDRP requirements).

As we mentioned above, in accordance with section 1833(t)(3)(C)(iv) of the Act, each year we update the OPPS conversion factor by an OPD fee schedule increase factor. For purposes of section 1833(t)(3)(C)(iv) of the Act, subject to sections 1833(t)(17) and 1833(t)(3)(F) of the Act, the OPD fee schedule increase factor is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000 and 2002.

For hospitals that do not meet the HOP QDRP reporting requirements discussed in section XVI. of this final rule with comment period, the update is equal to the OPD fee schedule increase factor less an additional 2.0 percentage points. In accordance with these statutory provisions, in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60419), we finalized an OPD fee schedule increase factor equal

to the IPPS full market basket update of 2.1 percent. Hospitals that failed to meet the HOP QDRP reporting requirements were subject to a reduced OPD fee schedule increase factor of 0.1 percent.

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

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

In the FY 2011 IPPS/LTCH final rule (75 FR 50352), consistent with current law, based on IHS Global Insight, Inc.'s second quarter 2010 forecast of the FY 2011 market basket increase, we estimated that the FY 2011 IPPS market basket update is 2.6 percent. However, consistent with the amendments to sections 1833(t)(3)(F)(ii) and (t)(3)(G)(i) of the Act, we are required to reduce the OPD fee schedule increase factor by 0.25 percentage point. Therefore, the market basket update to the CY 2011 OPD fee schedule increase factor is 2.35 percent (that is, the CY 2011 estimate of the OPD fee schedule increase factor of 2.6 percent minus 0.25 percentage point). For hospitals that do not meet the HOP QDRP reporting requirements, the update to the OPPS conversion factor is 0.35 percent (that is, the adjusted CY 2011 estimate of the market basket rate-of increase of 2.35 percent minus 2.0 percentage points).

In the CY 2011 OPPS/ASC proposed rule (75 FR 46226), we proposed to revise § 419.32(b)(1)(iv) of the regulations to reflect requirements of the Affordable Care Act for a 0.25 percentage point reduction to the OPPS fee schedule increase factor for each of CY 2010 and CY 2011.

Comment: One commenter supported the increase in the proposed conversion factor, which was updated by the market basket.

Response: We appreciate the commenter's support.

After consideration of the public comment we received, we are finalizing our proposed changes to § 419.32(b)(1)(iv), without modification, to reflect requirements of the Affordable Care Act for a 0.25 percentage point reduction to the OPPS fee schedule increase factor for each of CY 2010 and CY 2011. We are finalizing our CY 2011 proposal, without modification, to update the OPPS conversion factor by the FY 2011 OPD fee schedule increase factor, which is set at the IPPS market basket percentage increase of 2.6 percent minus the 0.25 percentage point reduction required under the Affordable Care Act, resulting in a final full conversion factor of $68.876 and in a reduced conversion factor of $67.530 for those hospitals that fail to meet the HOP QDRP reporting requirements for the full CY 2011 payment update.

C. Wage Index Changes

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

The OPPS labor-related share is 60 percent of the national OPPS payment. This labor-related share is based on a regression analysis that determined that, for all hospitals, approximately 60 percent of the costs of services paid under the OPPS were attributable to wage costs. We confirmed that this labor-related share for outpatient services is still appropriate during our regression analysis for the payment adjustment for rural hospitals in the CY 2006 OPPS final rule with comment period (70 FR 68553). Therefore, in the CY 2011 OPPS/ASC proposed rule (75 FR 46226), we did not propose to revise this policy for the CY 2011 OPPS. We refer readers to section II.H. of this final rule with comment period for a description and example of how the wage index for a particular hospital is used to determine the payment for the hospital.

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

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

The Affordable Care Act contains a number of provisions affecting the FY 2011 IPPS wage index values, including revisions to the reclassification wage

comparability criteria that were finalized in the FY 2009 IPPS final rule (73 FR 48568 through 48570), and the application of rural floor budget neutrality on a national, rather than State-specific, basis through a uniform, national adjustment to the area wage index. These specific provisions are discussed in more detail in the supplemental FY 2011 IPPS/LTCH PPS proposed rule published on June 2, 2010 in the **Federal Register** (75 FR 30920) and in the FY 2011 IPPS/LTCH PPS final rule which appears in the August 16, 2010 issue of the **Federal Register** (75 FR 50159). The Affordable Care Act also required CMS to establish an adjustment to create a wage index floor of 1.00 for hospitals located in States determined to be frontier States (section 10324). We discuss this provision and how it applies to hospital outpatient departments in more detail below.

Section 10324 of the Affordable Care Act specifies that, for services furnished beginning CY 2011, the wage adjustment factor applicable to any hospital outpatient department that is located in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II) of the Act) may not be less than 1.00. Further, section 10324 states that this adjustment to the wage index for these outpatient departments should not be made in a budget neutral manner. As such, for the CY 2011 OPPS, we proposed to adjust the wage index for all HOPDs, including those providers that are not paid under the IPPS, which are identified as being located in a frontier State, in the manner specified in the Affordable Care Act. Specifically, we proposed to adjust the FY 2011 IPPS wage index, as adopted on a calendar year basis for the OPPS, for all hospitals paid under the OPPS, including non-IPPS hospitals, located in a frontier State to 1.00 in instances where the assigned FY 2011 wage index (that reflects MGCRB reclassifications, application of the rural floor and rural floor budget neutrality adjustment) for these hospitals is less than 1.00. Similar to our current policy for HOPDs that are affiliated with multicampus hospital systems, we fully expect that the HOPD would receive a wage index based on the geographic location of the specific inpatient hospital with which it is associated. Therefore, if the associated hospital is located in a frontier State, the wage index adjustment applicable for the hospital would also apply for the affiliated HOPD. We refer readers to the FY 2011 IPPS/LTCH PPS final rule (75 FR 50160) for a detailed discussion regarding this provision, including our methodology for identifying which areas meet the definition of frontier States as provided for in section 1886(d)(3)(E)(iii)(II)) of the Act.

Comment: Commenters supported CMS' frontier State wage index proposal.

Response: We appreciate the commenters' support.

After consideration of the comments we received, we are finalizing our proposal, without modification, to adjust the FY IPPS 2011 wage index, as adopted on a calendar year basis for the OPPS, for all hospitals paid under the OPPS, including non-IPPS hospitals, located in a frontier State to 1.00 in instances where the assigned final FY 2011 wage index (that reflects MGCRB reclassifications, application of the rural floor and rural floor budget neutrality adjustment) for these hospitals is less than 1.00.

In addition, in the CY 2011 OPPS/ASC proposed rule (75 FR 46227), we proposed to revise 42 CFR 419.43(c) of the regulations to incorporate the amendments made by section 10324 of the Affordable Care Act. Specifically, we proposed to include a provision under a new paragraph (c)(2) of § 419.43 to state that, for services furnished beginning January 1, 2011, the wage adjustment factor referenced in the existing regulations applicable to any HOPD that is located in a frontier State, as defined in the statute and regulations, may not be less than 1.00. We also proposed to add a new paragraph (c)(3) to § 419.43 to not consider these additional payments in budget neutrality calculations.

We did not receive any public comments concerning our proposal to revise § 419.43(c) of the regulations to incorporate the amendments made by section 10324 of the Affordable Care Act. Therefore, we are finalizing our proposed revisions to § 419.43(c)(2) and (c)(3) without modification.

In addition to the changes required by the Affordable Care Act, we note that the FY 2011 IPPS wage indices continue to reflect a number of adjustments implemented over the past few years, including, but not limited to, revised Office of Management and Budget (OMB) standards for defining geographic statistical areas (Core-Based Statistical Areas or CBSAs), reclassification of hospitals to different geographic areas, rural floor provisions, an adjustment for out-migration labor patterns, an adjustment for occupational mix, and a policy for allocating hourly wage data among campuses of multicampus hospital systems that cross CBSAs. We refer readers to the FY 2011 IPPS/LTCH PPS final rule (75 FR 50157 through 50180) for a detailed discussion of all changes to the final FY 2011 IPPS wage indices, including changes required by the Affordable Care Act. In addition, we refer readers to the CY 2005 OPPS final rule with comment period (69 FR 65842 through 65844) and subsequent OPPS rules for a detailed discussion of the history of these wage index adjustments as applied under the OPPS.

The IPPS wage index that we are adopting in this final rule with comment period includes all reclassifications that are approved by the Medicare Geographic Classification Review Board (MGCRB) for FY 2011. We note that reclassifications under section 508 of Public Law 108–173 and certain special exception wage indices that were extended by section 106(a) of Public Law 109–432 (MIEA—TRHCA) and section 117 (a)(1) of Public Law 110–173 (MMSEA) were set to terminate September 30, 2008, but were further extended by section 124 of Public Law 110–275 (MIPPA) through September 30, 2009, and, most recently, by section 3137, as amended by section 10317, of the Affordable Care Act through September 30, 2010. We did not make any proposals related to these provisions for the CY 2010 OPPS wage index because the Affordable Care Act was enacted after issuance of the CY 2010 OPPS/ASC proposed and final rules. In accordance with section 10317 of the Affordable Care Act, for CY 2010, we adopted all section 508 geographic reclassifications through September 30, 2010. Similar to our treatment of section 508 reclassifications extended under Public Law 110–173 (MMSEA) as described in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68586), hospitals with section 508 reclassifications will revert to their home area wage index, with out-migration adjustment if applicable, or a current MGCRB reclassification, for the last quarter of CY 2010 (October 1, 2010 to December 31, 2010). In addition, as we did for CY 2009, we will recognize the revised wage index values for certain special exception hospitals from January 1, 2010 through December 31, 2010, under the OPPS, in order to give these hospitals the special exception wage indices under the OPPS for the same time period as under the IPPS. We refer readers to the section 508 reclassification discussion in the FY 2010 IPPS/LTCH PPS notice issued in the **Federal Register** on June 2, 2010 (75 FR 31118) for a detailed discussion of the changes to the wage indices as required by section 10317 of the Affordable Care Act. We also discuss the impact of the extension of reclassifications under section 508 and

special exception wage indices in the OPPS/ASC notice (CMS–1504–N) published in the **Federal Register** on August 3, 2010 (75 FR 45771). Because the provisions of section 10317 of the Affordable Care Act expire in 2010 (September 30, 2010) and are not applicable to FY 2011, as we proposed, we are not making any changes related to those provisions for the OPPS wage indices for CY 2011.

For purposes of the OPPS, as we proposed in the CY 2011 OPPS/ASC proposed rule (75 FR 46228), we are continuing our policy in CY 2011 to allow non-IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county. We note that because non-IPPS hospitals cannot reclassify, they are eligible for the out-migration wage adjustment. Table 4J in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50540) identifies counties eligible for the out-migration adjustment and providers receiving the adjustment. As we have done in prior years, we are reprinting Table 4J as Addendum L to this final rule with comment period with the addition of non-IPPS hospitals that will receive the section 505 out-migration adjustment under the CY 2011 OPPS.

As stated earlier in this section, we continue to believe that using the IPPS wage index as the source of an adjustment factor for the OPPS is reasonable and logical, given the inseparable, subordinate status of the HOPD within the hospital overall. Therefore, as we proposed, we are using the final FY 2011 IPPS wage indices for calculating OPPS payments in CY 2011. With the exception of the out-migration wage adjustment table (Addendum L to this final rule with comment period), which includes non-IPPS hospitals paid under the OPPS, we are not reprinting the FY 2011 IPPS final wage indices referenced in this discussion of the wage index. We refer readers to the CMS Web site for the OPPS at: *http://www.cms.gov/HospitalOutpatientPPS/*. At this link, readers will find a link to the FY 2011 IPPS final wage index tables.

Comment: Several commenters expressed support for the CMS proposal to extend the IPPS wage indices to the OPPS in CY 2011, consistent with prior year policies under the OPPS.

Response: We appreciate the commenters' support of our proposed CY 2011 wage index policies.

Comment: One commenter recommended that CMS incorporate a different labor-related share for APCs with high device or supply costs. The commenter suggested, based on its internal data analysis, that a labor-related share of 20 percent, rather than the current labor-related share of 60 percent, would be more appropriate for these APCs.

Response: We do not believe it is appropriate to vary the percentage of the national payment that is wage adjusted for different services provided under the OPPS. Such a change could not be considered without first assessing its impact on the OPPS labor-related share calculation. The OPPS labor-related share of 60 percent was determined through regression analyses conducted for the initial OPPS proposed rule (63 FR 47581) and confirmed for the CY 2006 OPPS final rule with comment period (70 FR 68556). The labor-related share is a provider-level adjustment based on the relationship between the labor input costs and a provider's average OPPS unit cost, holding all other things constant. While numerous individual services may have variable labor shares, these past analyses identified 60 percent as the appropriate labor-related share across all types of outpatient services and are the basis for our current policy. The provider-level adjustment is an aggregate, not service-specific, adjustment; it addresses payment for almost all services paid under the OPPS.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to use the final FY 2011 IPPS wage indices to adjust the OPPS standard payment amounts for labor market differences.

D. Statewide Average Default CCRs

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

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

We did not receive any public comments on our CY 2011 proposal. We are finalizing our proposal to apply our standard methodology of calculating the statewide average default CCRs using the same hospital overall CCRs that we used to adjust charges to costs on claims data. We used this methodology to calculate the statewide average default CCRs listed in Table 15 below.

For this CY 2011 OPS/ASC final rule with comment period, approximately 47 percent of the submitted cost reports utilized in the default ratio calculations represented data for cost reporting periods ending in CY 2009 and 52 percent were for cost reporting periods ending in CY 2008. For Maryland, we used an overall weighted average CCR for all hospitals in the nation as a substitute for Maryland CCRs. Few hospitals in Maryland are eligible to receive payment under the OPPS, which limits the data available to calculate an accurate and representative CCR. In general, observed changes in the statewide average default CCRs between CY 2010 and CY 2011 were modest and the few significant changes are associated with areas that have a small number of hospitals.

Table 15 below list the finalized statewide average default CCRs for OPPS services furnished on or after January 1, 2011.

TABLE 15—CY 2011 STATEWIDE AVERAGE CCRS

State	Urban/Rural	Final CY 2011 default CCR	Previous default CCR (CY 2010 OPPS final rule)
ALASKA	RURAL	0.479	0.499
ALASKA	URBAN	0.315	0.328
ALABAMA	RURAL	0.212	0.220
ALABAMA	URBAN	0.193	0.193
ARKANSAS	RURAL	0.223	0.251
ARKANSAS	URBAN	0.282	0.263
ARIZONA	RURAL	0.231	0.251
ARIZONA	URBAN	0.202	0.217
CALIFORNIA	RURAL	0.195	0.208
CALIFORNIA	URBAN	0.205	0.210
COLORADO	RURAL	0.350	0.345
COLORADO	URBAN	0.233	0.255
CONNECTICUT	RURAL	0.356	0.375
CONNECTICUT	URBAN	0.291	0.319
DISTRICT OF COLUMBIA	URBAN	0.313	0.324
DELAWARE	RURAL	0.279	0.320
DELAWARE	URBAN	0.362	0.363
FLORIDA	RURAL	0.185	0.198
FLORIDA	URBAN	0.172	0.184
GEORGIA	RURAL	0.246	0.265
GEORGIA	URBAN	0.220	0.246
HAWAII	RURAL	0.356	0.359
HAWAII	URBAN	0.308	0.307
IOWA	RURAL	0.252	0.332
IOWA	URBAN	0.288	0.302
IDAHO	RURAL	0.419	0.507
IDAHO	URBAN	0.384	0.409
ILLINOIS	RURAL	0.251	0.273
ILLINOIS	URBAN	0.239	0.253
INDIANA	RURAL	0.302	0.299
INDIANA	URBAN	0.270	0.296
KANSAS	RURAL	0.286	0.291
KANSAS	URBAN	0.215	0.226
KENTUCKY	RURAL	0.220	0.223
KENTUCKY	URBAN	0.244	0.254
LOUISIANA	RURAL	0.256	0.271
LOUISIANA	URBAN	0.235	0.259
MARYLAND	RURAL	0.284	0.294
MARYLAND	URBAN	0.256	0.267
MASSACHUSETTS	URBAN	0.314	0.323
MAINE	RURAL	0.460	0.433
MAINE	URBAN	0.450	0.452
MICHIGAN	RURAL	0.312	0.318
MICHIGAN	URBAN	0.320	0.320
MINNESOTA	RURAL	0.483	0.502
MINNESOTA	URBAN	0.311	0.330
MISSOURI	RURAL	0.258	0.266
MISSOURI	URBAN	0.264	0.270
MISSISSIPPI	RURAL	0.229	0.244
MISSISSIPPI	URBAN	0.182	0.192
MONTANA	RURAL	0.444	0.438
MONTANA	URBAN	0.399	0.462
NORTH CAROLINA	RURAL	0.254	0.270
NORTH CAROLINA	URBAN	0.264	0.285
NORTH DAKOTA	RURAL	0.351	0.333
NORTH DAKOTA	URBAN	0.360	0.361
NEBRASKA	RURAL	0.328	0.340
NEBRASKA	URBAN	0.259	0.260
NEW HAMPSHIRE	RURAL	0.323	0.329

TABLE 15—CY 2011 STATEWIDE AVERAGE CCRS—Continued

State	Urban/Rural	Final CY 2011 default CCR	Previous default CCR (CY 2010 OPPS final rule)
NEW HAMPSHIRE	URBAN	0.290	0.285
NEW JERSEY	URBAN	0.221	0.235
NEW MEXICO	RURAL	0.277	0.259
NEW MEXICO	URBAN	0.307	0.329
NEVADA	RURAL	0.269	0.296
NEVADA	URBAN	0.178	0.187
NEW YORK	RURAL	0.415	0.423
NEW YORK	URBAN	0.375	0.383
OHIO	RURAL	0.327	0.350
OHIO	URBAN	0.241	0.250
OKLAHOMA	RURAL	0.260	0.267
OKLAHOMA	URBAN	0.208	0.225
OREGON	RURAL	0.306	0.303
OREGON	URBAN	0.340	0.344
PENNSYLVANIA	RURAL	0.275	0.280
PENNSYLVANIA	URBAN	0.210	0.223
PUERTO RICO	URBAN	0.505	0.514
RHODE ISLAND	URBAN	0.284	0.299
SOUTH CAROLINA	RURAL	0.222	0.232
SOUTH CAROLINA	URBAN	0.227	0.242
SOUTH DAKOTA	RURAL	0.316	0.320
SOUTH DAKOTA	URBAN	0.251	0.261
TENNESSEE	RURAL	0.221	0.233
TENNESSEE	URBAN	0.204	0.214
TEXAS	RURAL	0.245	0.251
TEXAS	URBAN	0.216	0.222
UTAH	RURAL	0.386	0.397
UTAH	URBAN	0.362	0.400
VIRGINIA	RURAL	0.241	0.242
VIRGINIA	URBAN	0.263	0.255
VERMONT	RURAL	0.411	0.413
VERMONT	URBAN	0.365	0.397
WASHINGTON	RURAL	0.367	0.365
WASHINGTON	URBAN	0.327	0.340
WISCONSIN	RURAL	0.412	0.384
WISCONSIN	URBAN	0.334	0.329
WEST VIRGINIA	RURAL	0.291	0.283
WEST VIRGINIA	URBAN	0.337	0.339
WYOMING	RURAL	0.393	0.407
WYOMING	URBAN	0.296	0.315

E. OPPS Payment to Certain Rural and Other Hospitals

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

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

Section 5105 of Public Law 109–171 reinstituted the TOPs for covered OPD services furnished on or after January 1, 2006, and before January 1, 2009, for rural hospitals having 100 or fewer beds that are not SCHs. When the OPPS payment was less than the provider's pre-BBA amount, the amount of payment was increased by 95 percent of the amount of the difference between the two amounts for CY 2006, by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of that difference for CY 2008.

For CY 2006, we implemented section 5105 of Public Law 109–171 through Transmittal 877, issued on February 24, 2006. In the Transmittal, we did not

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

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

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

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

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60425), we stated that, effective for services provided on or after January 1, 2010, rural hospitals and SCHs (including EACHs) having 100 or fewer beds would no longer be eligible for TOPs, in accordance with section 147 of Public Law 110–275. However, subsequent to issuance of the CY 2010 OPPS/ASC final rule with comment period, section 3121(a) of the Affordable Care Act amended section 1833(t)(7)(D)(i)(III) of the Act by extending the period of TOPs to rural hospitals that are not SCHs with 100 beds or fewer for 1 year, for services provided before January 1, 2011. Section 3121(a) of the Affordable Care Act amended section 1833(t)(7)(D)(i)(III) of the Act and extended the period of TOPs to SCHs (including EACHs) for 1 year, for services provided before January 1, 2011, with section 3121(b) of the Affordable Care Act removing the 100-bed limitation applicable to such SCHs for covered OPD services furnished on and after January 1, 2010, and before January 1, 2011. In accordance with section 3121 of the Affordable Care Act, when the OPPS payment is less than the provider's pre-BBA amount, the amount of payment is increased by 85 percent of the amount of the difference between the two payment amounts for CY 2010. Accordingly, in the CY 2011 OPPS/ASC proposed rule (75 FR 46232), we proposed to update § 419.70(d) of the regulations to reflect the TOPs extensions and amendments described in section 3121 of the Affordable Care Act.

We did not receive any public comments on our proposed policy for updating the language in § 419.70(d) of the regulations. For the reasons we specify in the CY 2011 OPPS/ASC proposed rule (75 FR 46231–46232), we are finalizing our proposed revisions of § 419.70(d) without modification. Effective for services provided on or after January 1, 2011, rural hospitals having 100 or fewer beds that are not SCHs and SCHs (including EACHs) will no longer be eligible for hold harmless TOPs, in accordance with section 3121 of the Affordable Care Act.

2. Adjustment for Rural SCHs Implemented in CY 2006 Related to Public Law 108–173 (MMA)

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

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

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

For the CY 2011 OPPS, we proposed to continue our policy of a budget neutral 7.1 percent payment adjustment for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs (75 FR 46232). In the CY 2011 OPPS/ASC proposed rule, we indicated that we intend to reassess the 7.1 percent adjustment in the near future by

examining differences between urban and rural hospitals' costs using updated claims, cost reports, and provider information.

Comment: One commenter supported our proposal to continue to apply the budget neutral 7.1 percent adjustment to OPPS payment for rural sole community hospitals. The commenter also recommended that CMS update the analysis in the near future to assess if the 7.1 percent payment adjustment remains a valid figure.

Response: We agree that it is appropriate to continue the 7.1 percent adjustment for rural SCHs (including EACHs) as we proposed for CY 2011. As we indicated above, and in the proposed rule (75 FR 46232), we intended to reassess the 7.1 percent rural adjustment in the near future by examining differences between urban rural hospitals' costs using updated claims, cost reports, and provider information.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to apply the 7.1 percent payment adjustment to rural SCHs, including EACHs, for all services and procedures paid under the OPPS in CY 2011, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs.

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

1. Background

Since the inception of the OPPS, which was authorized by the Balanced Budget Act of 1997 (BBA), Medicare has paid cancer hospitals identified in section 1886(d)(1)(B)(v) of the Act (cancer hospitals) under the OPPS for covered outpatient hospital services. There are 11 cancer hospitals that meet the classification criteria in section 1886(d)(1)(B)(v) of the Act. These 11 cancer hospitals are exempted from payment under the IPPS. With the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, Congress created section 1833(t)(7) of the Act, "Transitional Adjustment to Limit Decline in Payment," to serve as a permanent payment floor by limiting cancer hospitals' potential losses under the OPPS. Through section 1833(t)(7)(D)(ii) of the Act, a cancer hospital receives the full amount of the difference between payments for covered outpatient services under the OPPS and a pre-BBA amount. That is, cancer hospitals are permanently held harmless to their "pre-BBA" amount, and they receive TOPs to ensure that they do not receive a payment that is lower under the OPPS than the payment they would have received before implementation of the OPPS, as set forth in section 1833(t)(7)(F) of the Act. The pre-BBA payment amount is an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base payment to cost ratio (base PCR) for the hospital. The pre-BBA amount, including the determination of the base PCR, are defined at 42 CFR 419.70(f). TOPs are calculated on Worksheet E, Part B, of the Hospital and Hospital Health Care Complex Cost Report (Form CMS–2552–96) each year. Section 1833(t)(7)(I) of the Act exempts TOPs from budget neutrality calculations. Almost all of the 11 cancer hospitals receive TOPs each year. The volume weighted average payment to cost ratio (PCR) for the cancer hospitals is 0.83, or outpatient payment with TOPs to cancer hospitals is 83 percent of reasonable cost.

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

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

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

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

While we chose not to use our standard models to calculate a proposed cancer hospital adjustment, we determined it still would be appropriate

to construct our usual provider-level analytical dataset consisting of variables related to assessing costliness, including average cost per unit for a hospital and the hospitals average APC relative weight as an indicator of the hospitals resource intensity, as measured by the APC relative weights. We used these variables to calculate univariate statistics that describe the costliness and related aspects of cancer hospitals and other hospitals paid under the OPPS. While descriptive statistics cannot control for the myriad factors that contribute to observed costs, we believe that we can assume that stark differences in cost between cancer hospitals and other hospitals paid under the OPPS that would be observable by examining descriptive univariate statistics would provide some indication of relative costliness. We began our analysis of the cancer hospitals as we did for the rural hospitals by creating an analytical dataset of hospitals billing under the OPPS for CY 2009 (a total of 3,933) that were included in our claims dataset for establishing the CY 2011 OPPS proposed APC relative weights (discussed in detail in section II.A. of this final rule with comment period). This analytical dataset includes the 3,933 OPPS hospitals' total estimated cost (including packaged cost), total lines, total discounted units as modeled for CY 2011 OPPS payment, and the average weight of their separately payable services (total APC weight divided by total units) as modeled for CY 2011 OPPS. We create this dataset from the hospital-specific service utilization files that we use to model budget neutrality and to perform impact analyses after we complete estimating a median cost (or equivalent amount depending on unique APC methodologies as discussed in section II of this final rule with comment period) for each APC. Using the CY 2009 claims that we use to model the CY 2011 proposed OPPS, we used the utilization on those claims to model APC payment under the CY 2011 proposed payment policies, such as proposed payment for drugs and biologicals at ASP+6 percent and proposed reassignment of some HCPCS codes to different APCs. We then summarized this estimated utilization and payment for each hospital ("hospital-level"). These files consist of hospital-level aggregate costs (including the cost of packaged items and services), total estimated discounted units under the modeled proposed CY 2011 OPPS, total estimated volume of number of occurrences of separately payable HCPCS codes under the modeled proposed CY 2011 OPPS, and total relative weight of separately payable services under the modeled proposed CY 2011 OPPS. The calculation of these summary files are discussed in Stage 6 of our claims accounting narrative available under supporting documentation for the proposed rule on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/HORD/.* After summarizing modeled payment to the hospital-level, we removed 48 hospitals in Puerto Rico from our dataset because we do not believe that their cost structure reflects the costs of most hospitals paid under the OPPS and because they could bias the calculation of hospital-weighted statistics. We then removed an additional 66 hospitals with a cost per unit of more than 3 standard deviations from the geometric mean (mean of the natural log) because including outliers in hospital-weighted descriptive statistics also could bias those statistics. This resulted in a dataset with 11 cancer hospitals and 3,808 other hospitals.

We included the following standard hospital-level variables that describe hospital costliness in our analysis file: Outpatient cost per discounted unit under the modeled CY 2011 OPPS (substituting a cost per administration, rather than a cost per unit, for drugs and biologicals); each hospital's proposed CY 2011 wage index as a measure of relative labor cost; the service mix index, or volume-weighted average proposed CY 2011 APC relative weight (including a simulated weight for drugs and biologicals created by dividing the CY 2010 April ASP-based payment amount at ASP+6 percent appearing in Addendum A and B of the proposed rule by the proposed conversion factor of $68.267); outpatient volume based on number of occurrences of HCPCS codes in the CY 2009 claims data; and number of beds. We used these variables because they are key indicators of costliness under the modeled OPPS system, and they allow us to assess the relative costliness of classes of hospitals under the proposed CY 2011 OPPS. We further discussed these variables in our CY 2006 proposed rule analysis (70 FR 42698 through 42701). A hospital's service mix index is a measure of resource intensity of the services provided by the hospital as measured by the proposed CY 2011 OPPS relative weights, and standardizing the cost per discounted unit by the service mix index creates an adjusted cost per unit estimate that reflects the remaining relative costliness of a hospital remaining after receiving the estimated payments that we proposed to make under the CY 2011 OPPS. In short, if a class of hospitals demonstrates higher cost per unit after standardization by service mix, it is an early indication that the class of hospitals may be significantly more costly in the regression models. We used these data to calculate the descriptive univariate statistics for cancer hospitals appearing in Table 16 below. We note that because drugs and biologicals are such a significant portion of the services that the cancer hospitals provide, and because section 3138 of the Affordable Care Act explicitly requires us to consider the cost of drugs and biologicals, we included the cost of these items in our total cost calculation for each hospital, counting each occurrence of a drug in the modeled proposed CY 2011 data (based on units in CY 2009 claims data). That is, we sought to treat each administration of a drug or biological as one unit.

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

TABLE 16—MEANS AND STANDARD DEVIATIONS FOR KEY VARIABLES BY CANCER AND NON-CANCER OPPS HOSPITALS

Variable	Cancer hospitals		Non-cancer hospitals	
	Mean	Standard deviation	Mean	Standard deviation
Outpatient Cost per Unit *	$344.20	(64.68)	$264.11	(165.86)

TABLE 16—MEANS AND STANDARD DEVIATIONS FOR KEY VARIABLES BY CANCER AND NON-CANCER OPPS HOSPITALS—Continued

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

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

3. Adjustment for Certain Cancer Hospitals

Having reviewed the cost data from the standard analytic database and determined that cancer hospitals are more costly than other hospitals within the OPPS system, we decided to examine hospital cost report data from Worksheet E, Part B (where TOPs are calculated on the Hospital and Hospital Health Care Complex Cost Report each year) in order to determine whether our findings were further supported by cost report data and to determine an appropriate proposed payment adjustment methodology. Analyses on our standard analytic database and descriptive statistics presented in Table 16 above, did not consider TOPs in assessing costliness of cancer hospitals relative to other hospitals furnishing services under section 1833(t) of the Act. This is because section 3138 of the Affordable Care Act requires that any cancer adjustment be made within the budget neutral system. In making a determination about a payment adjustment subject to budget neutrality, we believe it is appropriate to assess costliness and payments within the budget neutral payment system. We note that TOPs are based on reasonable cost and are not part of the budget neutral payment system. Further, TOPs have no associated relative weight that could be included in an assessment of APC-based payment. TOPs are paid at cost report settlement on an aggregate basis, not a per service basis, and we would have no way to break these payments down into a relative weight to incorporate these retrospective aggregate payments in the form of relative weight under the proposed modeled CY 2011 OPPS. The cost report data we selected for the analysis were limited to the OPPS-specific payment and cost data available on Worksheet E, Part B, which is also where TOPs are calculated including aggregate OPPS payments, including outlier payments and the cost of medical and other health services. These aggregate measures of cost and payment also include the cost and payment for drugs and biologicals and other adjustments that we typically include in our regression modeling, including wage index adjustment and rural adjustment, if applicable. While these cost report data cannot provide an estimate of cost per unit after controlling for other potential factors that could influence cost per unit, we can use this aggregate cost and payment data to examine the cancer hospitals' OPPS PCR and OPPS PCR with TOPs, and compare these to the OPPS PCR for other hospitals.

PCRs calculated from the most recent cost report data also indicate that costs relative to payments at cancer hospitals are higher than those at other hospitals paid under the OPPS (that is, cancer hospitals have lower PCRs). In order to calculate PCRs for hospitals paid under the OPPS (including cancer hospitals), we used the same extract of cost report data from the HCRIS, as discussed in section II.A. of this final rule with comment period, that we used to calculate the CCRs that we used to estimate median costs for the CY 2011 OPPS. Using these cost report data, we included data from Worksheet E, Part B for each hospital, keeping data from each hospital's most recent cost report, whether as submitted or settled. We then limited the dataset to the hospitals with CY 2009 claims data that we used to model the CY 2011 proposed APC relative weights (3,933 hospitals) because we used the claims from these hospitals to calculate the estimated costs we used for the descriptive statistics in our first analysis and because it is appropriate to use the same set of hospitals that we used to calibrate the modeled proposed CY 2011 OPPS. The cancer hospitals in this dataset largely had cost report data from cost reporting periods ending in FY 2008 and FY 2009. The cost report data for the other hospitals were from cost report periods with fiscal year ends ranging from 2005 to 2009. We then removed the cost report data for 48 hospitals from Puerto Rico from our dataset because we do not believe that their cost structure reflects the costs of most hospitals paid under the OPPS and, therefore, may bias the results of the study. We also removed 301 hospitals with cost report data that were not complete (missing OPPS payments including outliers, missing aggregate cost data, or both) so that all cost reports in the study would have both the payment and cost data necessary to calculate a PCR for each hospital, leading to a final analytic file of 3,584 hospitals with cost report data. We believe that the costs, PPS payments, and TOPs reported on Worksheet E, Part B for the hospitals included in our CY 2011 modeling should be sufficiently accurate for assessing hospital's relative costliness because all of the key elements that we believe to be necessary for the analysis (payment, cost, and TOPs) are contained on this worksheet.

Using this much smaller dataset of cost report data, we estimate that, on average, the OPPS payments to the 11 cancer hospitals, not including TOPs, are approximately 62 percent of reasonable cost (that is, we calculated a PCR of 0.615 for the cancer hospitals), whereas we estimate that, on average, the OPPS payments to other hospitals paid under the OPPS are approximately 87 percent of reasonable cost (resulting in a PCR of 0.868). Individual cancer hospitals' OPPS PCRs range from approximately 48 percent to approximately 82 percent. When TOPS are included in the calculation of the PCR, cancer hospitals, as a group, receive payments that are approximately 83 percent of reasonable cost, which is still lower than the average PCR of other OPPS hospitals of approximately 87 percent of reasonable cost. Considering these data, we find that the cancer hospitals are more costly than other hospitals paid under the OPPS. The dataset of hospital cost report data that

we used to model the proposed adjustment is available under supporting documentation for the proposed rule on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/HORD/*.)

Based on our findings that cancer hospitals, as a class, have a significantly lower volume weighted average PCR than the volume weighted PCR of other hospitals paid under the OPPS and our findings above that the cancer hospitals cost per discounted unit standardized for service mix remains much higher than the standardized cost per discounted unit of all other hospitals, in the CY 2011 OPPS/ASC proposed rule (75 FR 46235 to 46237), we proposed an adjustment for cancer hospitals to reflect these higher costs, effective January 1, 2011, as mandated by section 3138 of the Affordable Care Act. For purposes of calculating a proposed adjustment, we chose to rely on this straightforward assessment of payments and costs from the cost report data because of the concerns outlined above with respect to the small number of hospitals, and because of the challenges associated with accurately including drug and biological costs in our standard regression models. We believe that an appropriate adjustment would redistribute enough payments from other hospitals paid under the OPPS to the cancer hospitals to give cancer hospitals a PCR that is comparable to the average PCR for other hospitals paid under the OPPS. Therefore, we proposed a hospital-specific payment adjustment determined as the percentage of additional payment needed to raise each cancer hospital's PCR to the weighted average PCR for all other hospitals paid under OPPS (0.868) in the CY 2011 dataset. This would be accomplished by adjusting each cancer hospital's OPPS payment by the percentage difference between their individual PCR (without TOPs) and the weighted average PCR of the other hospitals paid under OPPS.

We stated in the proposed rule that the proposed methodology would result in the proposed percentage payment adjustments for the 11 cancer hospitals that appeared in Table 11 of the proposed rule. We proposed that this hospital-specific adjustment would be applied to the wage adjusted payments for all items, except for items and services paid at charges adjusted to cost or devices receiving pass-through status defined in 42 CFR 419.66. We proposed that the proposed cancer hospital adjustment would not be applied to items and services paid at charges adjusted to cost because these items and services are always paid the estimated full cost of the item or service. We proposed to amend the regulations at § 419.43 to add a new paragraph (i)(2) which would establish the amount of the adjustment to cancer hospitals. We also proposed that this adjustment would be budget neutral as set forth in proposed new § 419.43(i)(3), consistent with section 3138 of the Affordable Care Act. We note that outlier payments would be appropriately assessed after application of the cancer adjustment and that TOPs would continue to apply. The changes made by section 3138 of the Affordable Care Act do not affect the existing statutory provisions that provide for outlier payment for all hospitals paid under the OPPS, including cancer hospitals and TOPs payments for cancer hospitals. Further, both outlier payments and TOPs serve as a safety net for hospitals, although outliers are budget neutral and TOPs are not, and TOPs are limited to certain hospitals. As a means of buffering the financial risk associated with a prospective payment system, both adjustments (outliers and TOPs) only should be assessed after final payments have been made. Because outlier payments are made within the budget neutrality, outlier payments should be assessed after all budget neutral payments for an individual service have been made, including the cancer adjustment. The TOPs payments would be assessed after all payments have been made for a cost reporting period. We noted that the proposed adjustment for all cancer hospitals would have result in an estimated aggregate increase in OPPS payments to cancer hospitals of 41.2 percent for CY 2011 within the PPS system, based on cost report data, and a net increase in total payments, including TOPs payments, of 5 percent.

Comment: Many commenters urged CMS to consider TOPs when calculating the cancer hospital payment adjustment. The commenters stated that the proposed methodology to adjust each cancer hospital's OPPS payment by the percentage difference between their individual PCR without TOPs and the weighted average PCR of the other hospitals paid under OPPS results, largely, in a change in the form of outpatient payments to cancer hospitals by shifting payment from hold harmless payments under the TOPs provision to APC payments. This substitution of TOPs for APC payments, in turn, results in savings to the Medicare program which, the commenters asserted, is in violation of the statutory requirement that the policy be budget neutral. The commenters suggested that because the Congressional Budget Office scoring of section 3138 of the Affordable Care Act estimates no federal budgetary impact, Congress did not intend for savings under this provision.

Commenters also suggested that the associated budget neutral payment reduction of 0.7 percent is not appropriate or equitable to other hospitals paid under the OPPS. The commenters indicated that it was not the intent of Congress for the provision to impact the non-cancer hospitals in a manner that is disproportionate to the benefits obtained by the cancer hospitals. Many commenters noted that the majority of cancer care provided in the country is provided by the non-cancer hospitals that would experience a payment reduction under the proposal.

Commenters also expressed concern that the proposed payment adjustment increases beneficiary copayments. That is, they believed that the proposed cancer hospital adjustment would increase APC payments and, because beneficiary copayment is a percentage of the APC payment, Medicare beneficiaries seeking services at the 11 designated cancer hospitals will experience higher copayments due to the proposed methodology. One commenter suggested that the cancer hospitals could potentially lose more payment to bad debt under increased copayments than benefit from the proposed adjustment. The commenters strongly encouraged CMS to implement the adjustment in a way that does not increase beneficiary copayments.

Several commenters indicated that CMS selected an inappropriate benchmark against which to compare each cancer hospital's PCR. Specifically, the commenters indicated that CMS should have taken into account the concentration of outpatient services at the designated cancer hospitals as compared to other PPS hospitals and adjust the PCR benchmark higher. The commenters argued that other PPS hospitals have the ability to improve their Medicare margins through other payment systems, but that cancer hospitals receive the majority of their Medicare payments through the OPPS. These commenters asserted that because concentration of outpatient services was not considered in establishing the benchmark, the proposed adjustment was not valid.

Several commenters addressed CMS' study methodology. One commenter suggested that the CMS analysis is inadequate to conclude that costs are higher in cancer hospitals and that an adjustment is warranted. This commenter noted that the CMS analysis did not control for the many factors that

might explain differences in costliness or assess to what extent cost differences could be explained by differences in efficiency. This commenter also asserted that the exclusion of TOPs from the comparison of costliness distorts the analysis and makes the findings invalid. Another commenter suggested that CMS examine the costs of cancer patients generally for all hospitals, and compare the costs of these 11 hospitals to all hospitals providing cancer care to ensure an adjustment does not reinforce high-cost characteristics of the 11 designated cancer hospitals. One commenter requested that CMS confirm that it used a regression analysis, similar to that used to determine the current adjustment for rural SCHs (discussed in section II.E. of this final rule with comment period) and provide detail on coefficients and how CMS incorporated drugs into that model. Finally, the commenter requested that CMS confirm the bed size estimates in the analytic file that CMS made available with the proposed rule. Another commenter requested that CMS recalibrate the adjustment annually suggesting that the PCR for other hospitals will decline proportionate to the cancer hospital increase and that this should be reflected in any adjustment for future years.

Another commenter indicated that additional payments to cancer hospitals should be guided by quality of care and, because the Affordable Care Act requires the 11 cancer hospitals to begin submitting quality data in fiscal year 2014, suggested that additional payments to cancer hospitals be delayed until these quality data are available to serve as a basis for payment. Another commenter favored the adjustment, stating that it offered improved beneficiary access to cancer care.

Response: The many public comments we received have identified a broad range of very important issues and concerns associated with the proposed cancer hospital adjustment. After consideration of these public comments, we have determined that further study and deliberation related to these issues is critical. This process, however, will take a longer period of time than is permitted in order for us to meet the publication deadline of this final rule with comment period. Therefore, we are not finalizing an adjustment for certain cancer hospitals identified in section 1886(d)(1)(B)(v) of the Act at this time.

G. Hospital Outpatient Outlier Payments

1. Background

Currently, the OPPS pays outlier payments on a service-by-service basis. For CY 2010, the outlier threshold is met when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $2,175 fixed-dollar threshold. We introduced a fixed-dollar threshold in CY 2005 in addition to the traditional multiple threshold in order to better target outliers to those high cost and complex procedures where a very costly service could present a hospital with significant financial loss. If the cost of a service meets both of these conditions, the multiple threshold and the fixed-dollar threshold, the outlier payment is calculated as 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate. Before CY 2009, this outlier payment had historically been considered a final payment by longstanding OPPS policy. We implemented a reconciliation process similar to the IPPS outlier reconciliation process for cost reports with cost reporting periods beginning on or after January 1, 2009 (73 FR 68594 through 68599).

It has been our policy for the past several years to report the actual amount of outlier payments as a percent of total spending in the claims being used to model the proposed OPPS. Our current estimate of total outlier payments as a percent of total CY 2009 OPPS payment, using available CY 2009 claims and the revised OPPS expenditure estimate for the Trustee's Report for FY 2010, is approximately 1.3 percent of the total aggregated OPPS payments. Therefore, for CY 2009, we estimate that we paid 0.3 percent more than the CY 2009 outlier target of 1.0 percent of total aggregated OPPS payments.

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

2. Proposed Outlier Calculation

In the CY 2011 OPPS/ASC proposed rule (75 FR 46237 through 46238), we proposed for CY 2011 to continue our policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS for outlier payments. We proposed that a portion of that 1.0 percent, specifically 0.04 percent, would be allocated to CMHCs for PHP outlier payments. This is the amount of estimated outlier payments that would result from the proposed CMHC outlier threshold as a proportion of total estimated outlier payments. As discussed in section X.D. of this final rule with comment period, for CMHCs, as we proposed, we are continuing our longstanding policy that if a CMHC's cost for partial hospitalization services, paid under either APC 0172 (Level I Partial Hospitalization (3 services)) or APC 0173 (Level II Partial Hospitalization (4 or more services)), exceeds 3.40 times the payment for APC 0173, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate. For further discussion of CMHC outlier payments, we refer readers to section X.D. of this final rule with comment period.

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

We calculated the proposed fixed-dollar threshold for the CY 2010 OPPS/ASC proposed rule using largely the same methodology as we did in CY 2009 (73 FR 41462). For purposes of estimating outlier payments for the proposed rule, we used the hospital-specific overall ancillary CCRs available

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

As noted in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68011), we are concerned that we could systematically overestimate the OPPS hospital outlier threshold if we did not apply a CCR inflation adjustment factor. Therefore, we proposed to apply the same CCR inflation adjustment factor that we proposed to apply for the FY 2011 IPPS outlier calculation to the CCRs used to simulate the proposed CY 2011 OPPS outlier payments that determine the fixed-dollar threshold. Specifically, for CY 2011, we proposed to apply an adjustment of 0.9890 to the CCRs that were in the April 2010 OPSF to trend them forward from CY 2010 to CY 2011. The methodology for calculating this adjustment was discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24068 through 24070).

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

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

Comment: Several commenters supported the proposed fixed-dollar threshold for CY 2011 in order to maintain the target outlier spending percentage of 1.0 percent of total OPPS payments. One commenter supported CMS' proposal to develop the OPPS fixed-dollar outlier threshold using the same assumptions and projections that are used in the IPPS. One commenter believed that the proposed outlier fixed-dollar threshold was inappropriate and should be reduced because the CMS projection of estimated outlier spending for CY 2010 was only 0.85 percent in the CY 2011 OPPS/ASC proposed rule (75 FR 46237). That commenter recommended that the threshold be proportionally reduced based on the percentage difference between target and actual outlier percentage spending. One commenter requested that CMS release the "actual" percent that outlier payments represent of total OPPS payments for CY 2007 through CY 2009. One commenter believed that the threshold calculation should be based on actual payments rather than estimated payments, and requested that CMS provide the actual percents of OPPS spending that OPPS outliers represent. One commenter suggested that visit intensity data or diagnoses are not the only issues when looking at outliers, and that any methodology related to outliers should also consider a comprehensive look at resource utilization.

Response: We appreciate the commenters' support regarding the development of the OPPS outlier policy. We agree that the charge and CCR inflation factors that apply to inpatient hospitals services are equally applicable to services provided under the OPPS. As we discussed in our CY 2005 OPPS final rule, we believe that the use of this charge inflation factor is appropriate for OPPS because, with the exception of the routine service cost centers, hospitals use the same cost centers to capture costs and charges across inpatient and outpatient services (69 FR 65845). Therefore, as specified below, we are applying the charge inflation factors that were used to calculate the outlier fixed-dollar threshold for the IPPS in the calculation of the fixed-dollar threshold for the CY 2011 OPPS. We are not raising the threshold to account for the 0.15 percent of OPPS payment that we estimated was not paid relative to the target outlier percent of 1 percent for CY 2010 because we do not adjust the fixed-dollar threshold for prior year differences in actual expenditure of outlier payments. We believe that our proposed and final methodology uses the best available data we have at the time to yield the most accurate prospective fixed-dollar outlier threshold for the CY 2011 OPPS. The multiple and fixed-dollar thresholds are important parts of a prospective

payment system and should be based on projected payments using the latest available historical data without adjustments for prior year outlier payments. In this case, the 0.85 percent is only an estimate made from CY 2009 claims for purposes of presenting an impact of the change in the outlier threshold in the regulatory impact analysis. Although estimated outlier payments for the current PPS year, which appear in the impact tables, frequently are below the 1 percent target outlier spending percentage, as we discuss below, we more often than not pay slightly more than 1 percent of aggregate total OPPS payments in outlier payments in a given year. We continue to believe that it is appropriate to maintain the target outlier percentage of 1.0 percent of estimated aggregate total payment under the OPPS and to have a fixed-dollar threshold so that OPPS outlier payments are made only when the hospital would experience a significant loss for supplying a particular service.

With respect to the commenter that requested that we release the "actual" payment percentages for CY 2007 through CY 2009, we note that we have previously provided and continue to provide estimated actual percentage spending based on the claims data. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68592), using CY 2007 claims, we found OPPS outlier spending was 0.9 percent of the total aggregated OPPS payment for CY 2007. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60426), using CY 2008 claims, we found that OPPS outlier spending was 1.2 percent of the total aggregated OPPS payments for CY 2008. As discussed earlier in this section, using CY 2009 claims, we found that OPPS outlier spending was 1.3 percent of the total aggregated OPPS payments for CY 2009. We note that actual outlier payments can only be determined based on the claims data available and setting a prospective fixed-dollar outlier threshold without accounting for changes in CCRs and charges would potentially lead to greater inaccuracy in establishing the outlier fixed-dollar threshold. OPPS outliers account for the financial risk hospitals experience when providing an extraordinarily costly and complex service, and account for the resource utilization in the methodology by identifying the costs associated with providing services on each claim. We note that visit intensity data and diagnoses data are not incorporated into the calculation of the threshold because these are not components of OPPS payments or our longstanding policy for determining outlier eligibility and payment amount.

3. Final Outlier Calculation

For CY 2011, we are applying the overall CCRs from the July 2010 Outpatient Provider-Specific File with a CCR adjustment factor of 0.9910 to approximate CY 2011 CCRs to charges on the final CY 2009 claims that were adjusted to approximate CY 2011 charges (using the final 2-year charge inflation factor of 1.0988). These are the same CCR adjustment and charge inflation factors that were used to set the IPPS fixed-dollar threshold for the FY 2011 IPPS/LTCH PPS final rule (75 FR 50427 through 50431). We simulated aggregated CY 2011 hospital outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiple threshold constant and assuming that outlier payment would continue to be made at 50 percent of the amount by which the cost of furnishing the service would exceed 1.75 times the APC payment amount, until the total outlier payments equaled 1.0 percent of aggregated estimated total CY 2011 OPPS payments. We estimate that a fixed-dollar threshold of $2,025, combined with the multiple threshold of 1.75 times the APC payment rate, will allocate 1.0 percent of estimated aggregated total OPPS payments to outlier payments.

In summary, for CY 2011, we will continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the final fixed-dollar $2,025 threshold are met. For CMHCs, if a CMHC's cost for partial hospitalization services, paid under either APC 0172 or APC 0173, exceeds 3.40 times the payment for APC 0173, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate. We estimate that this threshold will allocate 0.02 percent of outlier payments to CMHCs for PHP outlier payments.

4. Outlier Reconciliation

In the CY 2009 OPPS/ASC final rule with comment period (73 CFR 68599), we adopted as final policy a process to reconcile hospital or CMHC outlier payments at cost report settlement for services furnished during cost reporting periods beginning in CY 2009. OPPS outlier reconciliation more fully ensures accurate outlier payments for those facilities whose CCRs fluctuate significantly relative to the CCRs of other facilities, and who receive a significant amount of outlier payments (73 FR 68598). As under the IPPS, we do not adjust the fixed-dollar threshold or the amount of total OPPS payments set aside for outlier payments for reconciliation activity because such action would be contrary to the prospective nature of the system. Our outlier threshold calculation assumes that overall ancillary CCRs accurately estimate hospital costs based on the information available to us at the time we set the prospective fixed-dollar outlier threshold. For these reasons, as we stated in the proposed rule, and have previously discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68596), we are not incorporating any assumptions about the effects of reconciliation into our calculation of the OPPS fixed-dollar outlier threshold.

Comment: One commenter asked that CMS report the amount of outlier reconciliation activity suggesting that, if the reconciled amounts are significant, these amounts should be factored into the annual fixed-dollar outlier threshold in the future. One commenter supported the current criteria for when OPPS outlier payments would go through a reconciliation process.

Response: We appreciate the commenter's support for our policy. As we discuss above, we do not take outlier reconciliation amounts into account in our projections of future outlier payments. It is difficult to predict the specific hospitals that will have CCRs and outlier payments that may be reconciled in any given year. We also note that reconciliation occurs because hospitals' actual CCRs for the cost reporting period are different from the interim CCRs used to calculate outlier payment when a bill is processed. Our fixed-dollar threshold calculation assumes that CCRs accurately estimate hospital costs based on information available to us at the time we set the prospective fixed-dollar threshold. Furthermore, we do not believe that estimating the fixed-dollar threshold to account for the amount of payment that is recovered or removed as a result of outlier reconciliation in any given year would necessarily result in a more accurate estimate of outlier payments or a more accurate calculation of the fixed-dollar threshold for outlier payment for the prospective payment year. In our experience modeling the OPPS fixed dollar threshold each year, changing the CCRs for a handful for hospitals would not typically result in enough change in estimated total outlier payments to change the modeled fixed dollar

threshold. For these reasons, we will not make any assumptions about the amount of anticipated reconciliation of outlier payments on the outlier threshold calculation nor will we report the amount of reconciliation activity.

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

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

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

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

Individual providers interested in calculating the payment amount that they would receive for a specific service from the national unadjusted payment rates presented in Addenda A and B to this final rule with comment period should follow the formulas presented in the following steps. For purposes of the payment calculations below, we refer to the national unadjusted payment rate for hospitals that meet the requirements of the HOP QDRP as the "full" national unadjusted payment rate. We refer to the national unadjusted payment rate for hospitals that fail to meet the requirements of the HOP QDRP as the "reduced" national unadjusted payment rate. The reduced national unadjusted payment rate is calculated by multiplying the reporting ratio of 0.980 times the "full" national unadjusted payment rate. The national unadjusted payment rate used in the calculations below is either the full national unadjusted payment rate or the reduced national unadjusted payment rate, depending on whether the hospital met its HOP QDRP requirements in order to receive the full CY 2011 OPPS increase factor.

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

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

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

$X = .60 *$ (national unadjusted payment rate)

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

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county, but who work in a different county with a higher wage index, in accordance with section 505 of Public Law 108–173. Addendum L to this final rule with comment period contains the qualifying counties and the associated wage index increase developed for the FY 2011 IPPS and published as Table 4J in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50450 through 50646). This step is to be followed only if the hospital is not reclassified or redesignated under section 1886(d)(8) or section 1886(d)(10) of the Act.

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

The formula below is a mathematical representation of Step 4 and adjusts the

labor-related portion of the national payment rate for the specific service by the wage index.

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

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

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

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

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

Y = .40 * (national unadjusted payment rate)

Adjusted Medicare Payment = $Y + X_a$

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

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

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

We have provided examples below of the calculation of both the full and reduced national unadjusted payment rates that will apply to certain outpatient items and services performed by hospitals that meet and that fail to meet the HOP QDRP requirements, using the steps outlined above. For purposes of this example, we use a provider that is located in Brooklyn, New York that is assigned to CBSA 35644. This provider bills one service that is assigned to APC 0019 (Level I Excision/Biopsy). The CY 2011 full national unadjusted payment rate for APC 0019 is $350.49. The reduced national unadjusted payment rate for a hospital that fails to meet the HOP QDRP requirements is $343.48. This reduced rate is calculated by multiplying the reporting ratio of 0.980 by the full unadjusted payment rate for APC 0019.

The FY 2011 wage index for a provider located in CBSA 35644 in New York is 1.3122. The labor-related portion of the full national unadjusted payment is $275.95 (.60 * $350.49 * 1.3122). The labor-related portion of the reduced national unadjusted payment is $270.43 (.60 * $343.48 * 1.3122). The nonlabor-related portion of the full national unadjusted payment is $140.20 (.40 * $350.49). The nonlabor-related portion of the reduced national unadjusted payment is $137.39 (.40 * $343.48). The sum of the labor-related and nonlabor-related portions of the full national adjusted payment is $416.15 ($275.95 + $140.19). The sum of the reduced national adjusted payment is $407.82 ($270.43 + $137.39).

I. Beneficiary Copayments

1. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining the unadjusted copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed a specified percentage. As specified in section 1833(t)(8)(C)(ii)(V) of the Act, for all services paid under the OPPS in CY 2010, and in calendar years thereafter, the percentage is 40 percent of the APC payment rate.

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

2. OPPS Copayment Policy

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

We did not receive any public comments regarding the proposed methodology for calculating copayments for CY 2011. Therefore, for the reasons set forth in the proposed rule (74 FR 46240), we are finalizing our CY 2011 copayment amounts without modification. We note that we received comments on the copayments that would apply to beneficiaries who receive services from dedicated cancer hospitals under our proposal to provide an adjustment to payments to these hospitals. Those copayment-related public comments are discussed in section II.F of this final rule with comment period.

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

Individuals interested in calculating the national copayment liability for a Medicare beneficiary for a given service provided by a hospital that met or failed to meet its HOP QDRP requirements should follow the formulas presented in the following steps.

Step 1. Calculate the beneficiary payment percentage for the APC by dividing the APC's national unadjusted copayment by its payment rate. For example, using APC 0019, $70.10 is 20 percent of the full national unadjusted payment rate of $350.49. For APCs with only a minimum unadjusted copayment in Addendum A and B of this final rule with comment period, the beneficiary payment percentage is 20 percent.

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

B is the beneficiary payment percentage.

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

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

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

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

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

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

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

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

III. OPPS Ambulatory Payment Classification (APC) Group Policies

A. OPPS Treatment of New HCPCS and CPT Codes

CPT and Level II HCPCS codes are used to report procedures, services, items, and supplies under the hospital OPPS. Specifically, CMS recognizes the following codes on OPPS claims: (1) Category I CPT codes, which describe medical services and procedures; (2) Category III CPT codes, which describe new and emerging technologies, services, and procedures; and (3) Level II HCPCS codes, which are used primarily to identify products, supplies, temporary procedures, and services not described by CPT codes. CPT codes are established by the American Medical Association (AMA) and the Level II HCPCS codes are established by the CMS HCPCS Workgroup. These codes are updated and changed throughout the year. CPT and HCPCS code changes that affect the OPPS are published both through the annual rulemaking cycle and through the OPPS quarterly update Change Requests (CRs). CMS releases new Level II HCPCS codes to the public or recognizes the release of new CPT codes by the AMA and makes these codes effective (that is, the codes can be reported on Medicare claims) outside of the formal rulemaking process via OPPS quarterly update CRs. This quarterly process offers hospitals access to codes that may more accurately describe items or services furnished and/or provides payment or more accurate payment for these items or services in a timelier manner than if CMS waited for the annual rulemaking process. We solicit comments on these new codes and finalize our proposals related to these codes through our annual rulemaking process. In the CY 2011 OPPS/ASC proposed rule (75 FR 46241 through 46246, we summarized and sought public comments on our process for updating codes as well as our proposed treatment of certain codes. As we proposed, in Table 17 below, using the April 1, 2010 through January 1, 2011 time period, we summarize our process for updating codes through our OPPS quarterly update CRs, seeking public comments, and finalizing their treatment under the OPPS. We note that because of the timing of the publication of the proposed rule, the codes implemented through the July 2010 OPPS quarterly update were not included in Addendum B but were listed in Table 14 of the proposed rule (75 FR 46243), while those codes based upon the April 2010 OPPS quarterly update were included in Addendum B.

TABLE 17—COMMENT TIMEFRAME FOR NEW OR REVISED HCPCS CODES

OPPS quarterly update CR	Type of code	Effective date	Comments sought	When finalized
April 1, 2010	Level II HCPCS Codes	April 1, 2010	CY 2011 OPPS/ASC proposed rule.	CY 2011 OPPS/ASC final rule with comment period.
July 1, 2010	Level II HCPCS Codes	July 1, 2010	CY 2011 OPPS/ASC proposed rule.	CY 2011 OPPS/ASC final rule with comment period.
	Category I (certain vaccine codes) and III CPT codes.	July 1, 2010	CY 2011 OPPS/ASC proposed rule.	CY 2011 OPPS/ASC final rule with comment period.
October 1, 2010	Level II HCPCS Codes	October 1, 2010	CY 2011 OPPS/ASC final rule with comment period.	CY 2012 OPPS/ASC final rule with comment period.
January 1, 2011	Level II HCPCS Codes	January 1, 2011	CY 2011 OPPS/ASC final rule with comment period.	CY 2012 OPPS/ASC final rule with comment period.
	Category I and III CPT Codes.	January 1, 2011	CY 2011 OPPS/ASC final rule with comment period.	CY 2012 OPPS/ASC final rule with comment period.

This process is discussed in detail below. We have separated our discussion into two sections based on whether we proposed to solicit public comments in the CY 2011 OPPS/ASC proposed rule or are soliciting public comments in this CY 2011 OPPS/ASC final rule with comment period. In the CY 2011 OPPS/ASC proposed rule, we noted that we sought public comments in the CY 2010 OPPS/ASC final rule with comment period on the new CPT and Level II HCPCS codes that were effective January 1, 2010. We also sought public comments in the CY 2010 OPPS/ASC final rule with comment period on the new Level II HCPCS codes effective October 1, 2009. These new codes with an effective date of October 1, 2009, or January 1, 2010, were flagged with comment indicator "NI" (New code, interim APC assignment; comments will be accepted on the interim APC assignment for the new code) in Addendum B to the CY 2010 OPPS/ASC final rule with comment period to indicate that we were assigning them an interim payment status and an APC and payment rate, if applicable, which were subject to public comment following publication of the CY 2010 OPPS/ASC final rule with comment period. We received public comments on the interim APC assignments for CPT codes 63663 (Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed), 63664 (Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed), 75571 (Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium), and 77338 (Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan) in the CY 2010 OPPS/ASC final rule with comment period. These codes were assigned to comment indicator "NI" in that final rule with comment period. We note that we also received the same comments for these codes from the CY 2011 OPPS/ASC proposed rule, and a summary of the comments and our responses with our discussion of our final treatment of these CPT codes can be found in section III.D. of this final rule with comment period.

1. Treatment of New Level II HCPCS Codes and Category I CPT Vaccine Codes and Category III CPT Codes for Which We Solicited Public Comments in the CY 2011 Proposed Rule

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

Through the April 2010 OPPS quarterly update CR (Transmittal 1924, Change Request 6857, dated February 26, 2010), we allowed separate payment for a total of 6 of the 22 Level II HCPCS codes. Specifically, as displayed in Table 18 below, these included HCPCS codes C9258 (Injection, telavancin, 10 mg), C9259 (Injection, pralatrexate, 1 mg), C9260 (Injection, ofatumumab, 10 mg), C9261 (Injection, ustekinumab, 1 mg), C9262 (Fludarabine phosphate, oral, 1 mg), and C9263 (Injection, ecallantide, 1 mg).

In addition to the six HCPCS C-codes, five new HCPCS G-codes were made effective on April 1, 2010. We did not recognize the five new HCPCS G-codes for separate payment under the OPPS because they were either paid under another Medicare payment system or were noncovered services under Medicare. Specifically, we assigned HCPCS codes G0432 (Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV–1 or HIV–2, screening), G0433 (Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV–1 or HIV–2, screening), G0435 (Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV–1 or HIV–2, screening), and G9143 (Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)), to status indicator "A" (Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS) to indicate that these services are paid under the Medicare Clinical Laboratory Fee Schedule (CLFS). Further, we did not recognize for separate payment HCPCS code G9147 (Outpatient Intravenous Insulin Treatment (OIVIT) and assigned it to status indicator "E" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) because this service is nationally a noncovered service under Medicare.

In the CY 2011 OPPS/ASC proposed rule, we solicited public comments on the status indicators and APC assignments of the 11 Level II HCPCS codes, which were listed in Table 13 of that proposed rule (75 FR 46242) and now appear in Table 18 of this final rule with comment period.

We did not receive any public comments on the proposed APC assignments and status indicators for the 11 Level II HCPCS codes included in Table 13 of the proposed rule. However, for CY 2011, the HCPCS Workgroup replaced the five of the six HCPCS C-codes with permanent HCPCS J-codes. Specifically, HCPCS code C9258 was replaced with HCPCS code J3095 (Injection, telavancin, 10 mg); HCPCS code C9259 with HCPCS code J9307 (Injection, pralatrexate, 1 mg); HCPCS code C9260 with HCPCS code J9302 (Injection, ofatumumab, 10 mg); HCPCS code C9261 with HCPCS code J3357 (Injection, ustekinumab, 1 mg); and HCPCS code C9263 with HCPCS code J1290 (Injection, ecallantide, 1 mg). We also note that HCPCS code C9262 was deleted on June 30, 2010, and replaced with HCPCS code Q2025 (Fludarabine phosphate oral, 1 mg) effective July 1, 2010. Finally, for the CY 2011 update, the HCPCS Workgroup deleted HCPCS code Q2025 and replaced it with HCPCS code J8562 (Fludarabine phosphate oral, 10 mg) effective January 1, 2011.

Consistent with our general policy of streamlining coding by using permanent HCPCS codes if appropriate rather than HCPCS C-codes for the reporting of drugs under the OPPS, we are showing the replacement HCPCS J-codes for the same descriptor in Table 18 that replace the HCPCS C-codes first implemented in April 2010, effective January 1, 2011. With the exception of HCPCS code C9262, which was deleted June 30, 2010, all five HCPCS C-codes will be deleted on December 31, 2010. Because HCPCS codes C9258, C9259, C9260, C9261, and C9263 describe the same drugs and the same dosages currently designated by HCPCS codes J3095, J9307, J9302, J3357, and J1290, respectively, these drugs will continue their pass-through status in CY 2011. Therefore, we are assigning HCPCS codes J3095, J9307, J9302, J3357, and J1290 to the same status indicators and APCs as their predecessor C-codes, as shown in Table 18.

We did not receive any public comments on the new Level II HCPCS

codes that were implemented in April 2010. Therefore, as discussed in the CY 2011 OPPS/ASC proposed rule (75 FR 46242), we are adopting as final for CY 2011, without modification, our proposal to assign the Level II HCPCS codes listed in Table 18 to the specific APCs and status indicators set forth in the CY 2011 OPPS/ASC proposed rule. Table 18 below shows the final APC and status indicator assignments for all 11 Level II HCPCS codes.

TABLE 18—LEVEL II HCPCS CODES WITH A CHANGE IN OPPS STATUS INDICATOR OR NEWLY IMPLEMENTED IN APRIL 2010

CY 2011 HCPCS Code	CY 2010 HCPCS Code	CY 2011 Long descriptor	Final CY 2011 Status Indicator	Final CY 2011 APC
J3095	C9258	Injection, telavancin, 10 mg	G	9258
J9307	C9259	Injection, pralatrexate, 1 mg	G	9259
J9302	C9260	Injection, ofatumumab, 10 mg	G	9260
J3357	C9261	Injection, ustekinumab, 1 mg	G	9261
J8562	C9262	Fludarabine phosphate, oral, 10 mg	G	1339
J1290	C9263	Injection, ecallantide, 1 mg	G	9263
G0432	G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, qualitative or semiquantitative, multiple-step method, HIV–1 or HIV–2, screening.	A	NA
G0433	G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV–1 or HIV–2, screening.	A	NA
G0435	G0435	Infectious agent detection by rapid antibody test of oral mucosa transudate, HIV–1 or HIV–2, screening.	A	NA
G9143	G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s).	A	NA
G9147	G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration.	E	NA

*Level II HCPCS code C9262 was deleted June 30, 2010, and replaced with HCPCS code Q2025 effective July 1, 2010. Level II HCPCS code Q2025 will be deleted on December 31, 2010, and replaced with HCPCS code J8562 effective January 1, 2011.

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

We note that HCPCS code C9262 was made effective April 1, 2010, and deleted June 30, 2010, when it was replaced with HCPCS code Q2025. As discussed in section V.A.3. of the CY 2011 OPPS/ASC proposed rule, pass-through status began for this drug on April 1, 2010. Because HCPCS code Q2025 describes the same drug as HCPCS code C9262, we are continuing its pass-through status and assigning the HCPCS Q-code to the same APC and status indicator as its predecessor HCPCS C-code, as shown in Table 19. Specifically, HCPCS code Q2025 is assigned to APC 9262 with a status indicator "G."

Of the 12 HCPCS codes that were made effective July 1, 2010, we did not recognize 4 HCPCS codes for separate payment. Specifically, we did not recognize HCPCS codes G0428 (Collagen Meniscus Implant procedure for filling meniscal defects (*e.g.*, CMI, collagen scaffold, Menaflex)), G0429 (Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (*e.g.*, as a result of highly active antiretroviral therapy), Q2026 (Injection, Radiesse, 0.1 ml), and Q2027 (Injection, Sculptra, 0.1 ml). Under the hospital OPPS, we have assigned HCPCS code G0428 to status indicator "E" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) because this service is nationally noncovered by Medicare. Further, because HCPCS code C9800 describes both the injection procedure and the dermal filler supplies, we have assigned HCPCS codes G0429, Q2026, and Q2027 to status indicator "B" to indicate that these HCPCS codes are not recognized by OPPS when submitted on an outpatient hospital Part B bill type 12x and 13x. Specifically, hospitals must report HCPCS code C9800 to report the dermal filler supplies and the dermal filler injection procedure. Under the hospital OPPS, we have assigned HCPCS code C9800 to APC 0135 with a status indicator "T."

Comment: One commenter stated that the proposed payment rate for HCPCS code C9800 does not cover the cost of Sculptra. The commenter requested that CMS reevaluate the proposed payment rate for HCPCS code C9800 to ensure that it covers a hospital's acquisition cost and that Medicare provide access to this nationally covered therapy. The commenter provided no pricing information for Sculptra or other supplies used in this procedure.

Response: The payment rate for HCPCS code C9800 for CY 2011 includes both the administration of the dermal fillers as well as the dermal filler supplies. We further stated in the CY 2011 OPPS/ASC proposed rule (75 FR 46242) that because the payment for HCPCS code C9800 includes both the injection procedure and the dermal filler supplies, we have assigned HCPCS codes G0429, Q2026, and Q2027 to indicator "B" to indicate that these HCPCS codes are not recognized by OPPS when submitted on a hospital outpatient Part B bill types 12x and 13x.

Specifically, hospital outpatient facilities must use HCPCS code C9800 to report dermal filler supplies and the dermal filler injection procedure. Although there are two HCPCS codes that describe dermal filler supplies, specifically, HCPCS codes Q2026 for Radiesse and Q2027 for Sculptra, CMS has not received ASP pricing for these two products. Under the OPPS, there is no provision to contractor-price drugs and biologicals, and without ASP information, we could not recognize the Q-codes for separate payment. We will reevaluate the status indicator assignments for the HCPCS codes that describe dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) once we receive ASP information for the dermal filler supplies. That is, we will reevaluate the APC and status indicator assignments for HCPCS codes C9800, G0429, Q2026, and Q20207.

Also, it should be noted that with all new codes for which we lack pricing information, our policy has been to assign the service to an existing APC based on input from a variety of sources, including, but not limited to, review of the clinical similarity of the service to existing procedures; input from CMS medical advisors; information from interested specialty societies; and review of all other information available to us. The OPPS is a prospective payment system that provides payment for groups of services that share clinical and resource use characteristics. Based on our review, we believe that the service described by HCPCS code C9800 shares similar resource and clinical characteristics to the procedures included in APC 0135 (Level III Skin Repair). Although we currently do not have ASP information for the dermal filler supplies, we believe that the service is appropriately placed in APC 0135 based on the latest available information that we have. We believe that the service described by HCPCS code C9800 is analogous to those services currently assigned to APC 0135 because HCPCS code C9800 and the procedures listed in this APC relate to procedures involving the skin, and HCPCS code C8900 and other procedures in this APC involve injection(s) into the dermal layers.

Therefore, after consideration of the public comment we received, we are adopting as final, without modification, our proposal to continue to assign HCPCS code C9800 to APC 0135, which has a final CY 2011 APC median cost of approximately $316.

We did not receive any public comments on the other proposed APC assignments and status indicators for the other 11 Level II HCPCS codes listed in Table 14 of the CY 2011 OPPS/ASC proposed rule. However, for CY 2011, the HCPCS Workgroup replaced the six HCPCS C-codes with permanent HCPCS J-codes. Specifically, HCPCS code C9264 was replaced with HCPCS code J3262 (Injection, tocilizumab, 1 mg); HCPCS code C9265 was replaced with HCPCS code J9315 (Injection, romidepsin, 1 mg); HCPCS code C9266 was replaced with HCPCS code J0775 (Injection, collagenase clostridium histolyticum, 0.01 mg); HCPCS code C9267 was replaced with HCPCS code J7184 (Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO); HCPCS code C9268 was replaced with J7335 (Capsaicin 8% patch, per 10 square centimeters); and HCPCS code Q2025 (previously described as HCPCS code C9262) was replaced with HCPCS code J8562 (Fludarabine phosphate oral, 10 mg).

Consistent with our general policy of using permanent HCPCS codes if appropriate rather than HCPCS C-codes for the reporting of drugs under the OPPS in order to streamline coding, we are showing the replacement HCPCS J-codes in Table 19 that will replace the HCPCS C-codes, effective January 1, 2011. Because HCPCS codes C9264, C9265, C9267, and C9268 describe the same drugs and the same dosages currently designated by HCPCS codes J3262, J9315, J7184, and J7335, respectively, these drugs will continue their pass-through status in CY 2011. Therefore, we are assigning HCPCS codes J3262, J9315, J7184, and J7335 to the same status indicators and APCs as their predecessor C-codes, as shown in Table 19. We note that replacement codes for HCPCS codes C9266 and Q2025 do not describe the same dosage descriptors, and consequently, the replacement HCPCS codes will be given new APCs. Specifically, HCPCS code C9266 describes a dosage descriptor of 0.1 mg, however, its replacement HCPCS code J0775 describes a dosage descriptor of 0.01 mg. Similarly, HCPCS code Q2025 describes a dosage descriptor of 1 mg; however, its replacement HCPCS code J8562 describes a dosage descriptor of 10 mg. For CY 2011, HCPCS codes J0775 and J8562 are assigned to APC 1340 and APC 1339, respectively. Because their predecessor codes were assigned to pass-through status, both HCPCS codes J0775 and J8562 continue to be assigned to status indicator "G" for CY 2011. We note that we generally assign only one APC to those HCPCS codes that describe separately payable drugs, and maintain that same APC when there is no change to the dosage descriptor of a HCPCS drug code. Alternatively, when there is a change to the dosage descriptor, we will reassign the separately payable HCPCS drug code to a new APC to maintain data consistency for future rulemaking.

After consideration of the public comment that we received, we are adopting as final, without modification, our proposal to assign the Level II HCPCS codes listed in Table 19 to the APCs and status indicators as proposed for CY 2011. Table 19 below includes a complete list of the HCPCS codes that were made effective July 1, 2010, with their status indicators and APC assignment for CY 2011.

TABLE 19—NEW LEVEL II HCPCS CODES IMPLEMENTED IN JULY 2010

CY 2011 HCPCS Code	CY 2010 HCPCS Code	CY 2011 Long descriptor	Final CY 2011 status indicator	Final CY 2011 APC
J3262	C9264	Injection, tocilizumab, 1 mg	G	9264
J9315	C9265	Injection, romidepsin, 1 mg	G	9265
J0775	C9266	Injection, collagenase clostridium histolyticum, 0.01 mg	G	1340
J7184	C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO.	G	9267
J7335	C9268	Capsaicin 8% patch, per 10 square centimeters	G	9268
C9367	C9367	Skin substitute, Endoform Dermal Template, per square centimeter	G	9367
C9800	C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies.	T	0135

TABLE 19—NEW LEVEL II HCPCS CODES IMPLEMENTED IN JULY 2010—Continued

CY 2011 HCPCS Code	CY 2010 HCPCS Code	CY 2011 Long descriptor	Final CY 2011 status indicator	Final CY 2011 APC
G0428	G0428	Collagen meniscus implant procedure for filling meniscal defects (*e.g.*, CMI, collagen scaffold, Menaflex).	E	NA
G0429	G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (*e.g.,* as a result of highly active antiretroviral therapy).	B	NA
J8562	Q2025	Fludarabine phosphate oral, 10 mg	G	1339
Q2026	Q2026	Injection, Radiesse, 0.1 ml	B	NA
Q2027	Q2027	Injection, Sculptra, 0.1 ml	B	NA

For CY 2011, we proposed to continue our established policy of recognizing Category I CPT vaccine codes for which FDA approval is imminent and Category III CPT codes that the AMA releases in January of each year for implementation in July through the OPPS quarterly update process. Under the OPPS, Category I vaccine codes and Category III CPT codes that are released on the AMA Web site in January are made effective in July of the same year through the July quarterly update CR, consistent with the AMA's implementation date for the codes. Through the July 2010 OPPS quarterly update CR, we allowed separate payment for 10 of the 11 new Category III CPT codes effective July 1, 2010. Specifically, as displayed in Table 15 of the proposed rule, we allow separate payment for CPT codes 0223T (Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report), 0224T (Multiple, including serial trended analysis and limited reprogramming of device parameter—AV or VV delays only, with interpretation and report), 0225T (Multiple, including serial trended analysis and limited reprogramming of device parameter—AV and VV delays, with interpretation and report), 0226T (Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed), 0227T (Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)), 0228T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level), 0229T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)), 0230T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level), 0231T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)), and 0232T (Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed). We note that CMS has issued a national coverage determination (NCD) of noncoverage specifically for chronic, non-healing cutaneous wounds and acute surgical wounds when the autologous platelet rich plasma (PRP) is applied directly to the closed incision or for dehiscent wounds. Category III CPT code 0232T has been assigned to APC 0340 to provide a payment amount when payment is appropriate, both under the NCD provisions and any local coverage determinations. Under the hospital OPPS, Category III CPT code 0233T (Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy) is not recognized under the hospital OPPS. However, the service is paid under the MPFS.

Further, CMS does not recognize the four new H1N1 Category I CPT vaccine codes or the administration code that are effective on July 1, 2010, for separate payment under the OPPS because we already recognize an existing HCPCS G-code for reporting the H1N1 vaccine, specifically HCPCS code G9142 (Influenza a (h1n1) vaccine, any route of administration) and an existing HCPCS G-code G9141 ((Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)) for reporting the administration of that vaccine, which was effective September 1, 2009. We have assigned HCPCS code G9142 to status indicator "E" under the OPPS because the vaccine is expected to be free. Consequently, Category I CPT vaccine codes 90470 (H1N1 immunization administration (intramuscular, intranasal), including counseling when performed), 90664 (Influenza virus vaccine, pandemic formulation, live, for intranasal use), 90666 (Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use), 90667 (Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use), and 90668 (Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use), are assigned to status indicator "E" (Not paid under OPPS or any other Medicare payment system). We note that CPT code 90470 was effective September 28, 2009, when it was released by the AMA on its Web site.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46243 through 46245), we solicited public comments on the proposed status indicators and the APC assignments for the new Category I and III CPT codes. We received public comments on our payment proposal for CPT code 0232T, and our coding proposal not to recognize the H1N1 CPT codes 90470, 90664, 90666, 90667, and 90668.

Comment: One commenter requested that CMS reevaluate the APC assignment for CPT code 0232T, which is assigned to APC 0340 (Minor Ancillary Procedures) with a proposed payment rate of $47.10 for CY 2011, based on additional cost data that may be provided to CMS.

Response: As part of our review for new CPT codes available mid-year, we examine the APC assignments for all items and services under the OPPS for appropriate placements in the context of our proposed policies for the update year. This review involves careful analysis of data we have available to us, such as the cost of comparable items or services, as well as input from our medical advisors, the APC Panel, and recommendations from the public. Based on our analysis of the service associated with Category III CPT code 0232T, we believe that APC 0340 is the

most appropriate assignment based on its clinical and resource considerations to other procedures currently assigned in APC 0340. When the CY 2011 claims data become available for future rulemaking, we will reevaluate the cost of the service described by Category III CPT code 0232T to assess the appropriateness of the structure of APC 0340 and its payment rate.

Therefore, after consideration of the public comments we received, we are finalizing our proposal, without modification, to continue to assign CPT code 0232T to APC 0340, which has a final CY 2011 APC median cost of approximately $46.

Comment: Several commenters requested that CMS recognize the H1N1 vaccine administration CPT code 90470 and the four H1N1 vaccine CPT codes, specifically CPT codes 90664, 906606, 90667, and 90668, because they are more descriptive than the Level II HCPCS codes G9141 and G9142 describing to the same vaccine and its administration. These commenters stated that it is operationally burdensome for hospitals to report one code to Medicare and another code to other payers for the same service, and requested the deletion of the temporary HCPCS codes G9141 and G9142 to enable a single, standard mechanism for reporting these services across all payers.

Response: While we agree that CPT codes 90470, 90664, 906606, 90667, and 90668 are more descriptive than the Level II HCPCS codes G9141 and G9142, payment for H1N1 services are not based on specific formulations of the H1N1 administered to Medicare beneficiaries. The new CPT codes describe specific formulations of H1N1, which are not required for Medicare payment. Further, we do not recognize the H1N1 vaccine and administration CPT codes because Medicare already recognizes two existing Level II HCPCS codes G9141 and G9142 to describe the H1N1 vaccine and its administration. As we stated in the October 2009 OPPS update change request (Transmittal 1803, Change Request 6626), Level II HCPCS codes G9141 and G9142 were made effective September 1, 2009.

After consideration of the public comments we received, we are finalizing our proposal, without modification. For CY 2011, we are continuing our established policy of recognizing Category I CPT vaccine codes for which FDA approval is imminent and Category III CPT codes that the AMA releases in January of each year for implementation in July through the OPPS quarterly update process. Specifically, for CY 2011 under the OPPS, we are recognizing the current HCPCS codes G9141 and G9142 and are not recognizing the H1N1 vaccine and administration CPT codes 90470, 90664, 90666, 90667, and 90668. Moreover, we are assigning HCPCS code G9141 to APC 0350, which has a final CY 2011 APC median cost of approximately $26, and assigning HCPCS code G9142 to status indicator "E." Table 20 below lists the Category I CPT vaccine and Category III CPT codes that were implemented in July 2010 for which we are allowing separate payment, along with their status indicators, APC assignments, and payment rates for CY 2011.

TABLE 20—CATEGORY I VACCINE AND CATEGORY III CPT CODES IMPLEMENTED IN JULY 2010

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46243 through 46246), we solicited public comments on the CY 2011 proposed status indicators and the proposed APC assignments and payment rates, if applicable, for the Level II HCPCS codes and the Category I vaccine codes and Category III CPT codes that are newly recognized in April or July 2010 through the respective OPPS quarterly update CRs. These codes were listed in Tables 13, 14, and

15 of the proposed rule. We proposed to finalize their status indicators and their APC assignments and payment rates, if applicable, in this CY 2011 OPPS/ASC final rule with comment period. Because the July 2010 OPPS quarterly update CR is issued close to the publication of the proposed rule, the Level II HCPCS codes and the Category I vaccine and Category III CPT codes implemented through the July 2010 OPPS quarterly update CR could not be included in Addendum B to the proposed rule. These codes are listed in Tables 19 and 20, respectively, of this final rule with comment period, and are incorporated into Addendum B to this final rule with comment period, which is consistent with our annual OPPS update policy. The Level II HCPCS codes implemented or modified through the April 2010 OPPS update CR and displayed in Table 18 are included in Addendum B to this final rule with comment period, where their CY 2011 payment rates also are shown. We did not receive any additional comment on this process. Therefore, as we explained in the CY 2011 OPPS/ASC proposed rule (75 FR 46243 through 46246), we are finalizing the status indicators and their APC assignments and payment rates, if applicable, for Category I vaccine codes and Category III CPT codes that are newly recognized in April or July 2010, in this CY 2011 OPPS/ASC final rule with comment period.

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

As has been our practice in the past, we incorporate those new Category I and III CPT codes and new Level II HCPCS codes that are effective January 1 in the final rule with comment period updating the OPPS for the following calendar year. These codes are released to the public via the CMS HCPCS (for Level II HCPCS codes) and AMA Web sites (for CPT codes), and also through the January OPPS quarterly update CRs. In the past, we also have released new Level II HCPCS codes that are effective October 1 through the October OPPS quarterly update CRs and incorporated these new codes in the final rule with comment period updating the OPPS for the following calendar year. All of these codes are flagged with comment indicator "NI" in Addendum B to the OPPS/ASC final rule with comment period to indicate that we are assigning them an interim payment status which is subject to public comment. Specifically, the status indicator and the APC assignment, and payment rate, if applicable, for all such codes flagged with comment indicator "NI" are open to public comment in the final rule with comment period, and we respond to these comments in the OPPS/ASC final rule with comment period for the next calendar year's OPPS/ASC update. In the CY 2011 OPPS/ASC proposed rule (75 FR 46246), we proposed to continue this process for CY 2011. Specifically, for CY 2011, we proposed to include in Addendum B to the CY 2011 OPPS/ASC final rule with comment period the new Category I and III CPT codes effective January 1, 2011 (including those Category I vaccine and Category III CPT codes that were released by the AMA in July 2010) that would be incorporated in the January 2011 OPPS quarterly update CR and the new Level II HCPCS codes, effective October 1, 2010, or January 1, 2011, that would be released by CMS in its October 2010 and January 2011 OPPS quarterly update CRs. As proposed, these codes are flagged with comment indicator "NI" in Addendum B to this CY 2011 OPPS/ASC final rule with comment period to indicate that we have assigned them an interim OPPS payment status for CY 2011. Their status indicators and their APC assignments and payment rates, if applicable, are open to public comment in this final rule with comment period and will be finalized in the CY 2012 OPPS/ASC final rule with comment period. We note that the Category I vaccine and Category III CPT codes that were released by the AMA in July 2010 that were subject to comment in the CY 2011 OPPS/ASC proposed rule, and were listed in Table 15, will not be assigned to comment indicator "NI" in Addendum B because comments about these codes are addressed in this final rule with comment period.

Comment: Some commenters requested that CMS reconsider the timeline for APC assignments for new CPT and HCPCS codes for which comments are sought. The commenters indicated that the current schedule has the potential to produce long gaps of inappropriate payment with no mechanism for changes over the short term period. One commenter suggested including the new Category I CPT codes that are approved in February to be included in the proposed rule to enable interested parties to comment on the interim payment values before they are finalized. This commenter further recommended that CMS should be prepared to implement corrections on a quarterly basis.

Response: With respect to the comment regarding new Category I CPT codes that are effective in February, we believe the commenter meant the new Category I CPT codes that are released in late September or October when the annual CPT code book for the upcoming year are published that are then implemented in January, which are not discussed in the proposed rule but are published in the final rule with comment period. Because the CPT codes for the January 2011 update were not issued to the public until October 2010 when AMA published the CY 2011 CPT codes, we could not include them in the CY 2011 OPPS/ASC proposed rule for comment because the proposed rule is published in the summer, usually several months in advance of the publication of the CPT code books. Similarly, the Level II HCPCS codes that are made effective in October are published after the publication of the proposed rule. Because these codes are released after the publication of the proposed rule, we do not discuss either the new Category I CPT codes or the Level II HCPCS codes that are effective for the upcoming January in the proposed rule, which is published sometime in the summer.

As has been our practice for the past several years, we list the new Category I CPT codes and the Level II HCPCS codes in the final rules and flag them with comment indicator "NI" (New code, interim APC assignment; comments will be accepted on the interim APC assignment for the new code) in Addendum B to indicate that the codes are assigned to an interim payment status and an APC and payment rate, if applicable, that is subject to public comment following the publication of the final rule with comment period. For these new codes, we are only able to finalize their assignments in another OPPS final rule in order to allow for the necessary public notice and comment period and to allow time for CMS to respond to such comments. Therefore, we only assign HCPCS codes permanently for the year through the annual regulatory process.

Because we are not able to revise APC and/or status indicator assignments for the newly implemented HCPCS codes in CY 2010 that are assigned an interim final status in this CY 2011 OPPS/ASC final rule with comment period outside of the rulemaking process, the next available opportunity to update an APC or status indicator for these codes is in the CY 2012 final rule with comment period. These HCPCS codes retain their interim final APC and status indicator assignments for all of CY 2011. Therefore, only in the CY 2012 OPPS/ASC final rule with comment period will we be able to finalize the APC and/

or status indicator assignments of the new CY 2011 HCPCS codes and respond to all public comments received on their interim designations.

We also cannot implement any changes in status indicator or APC assignment on a quarterly basis because we have an annual process subject to notice and comment for the assignment of a status indicator and, if applicable, APC group. Therefore, actual changes to status indicator or APC assignments cannot be implemented on a quarterly basis.

After consideration of the public comments we received, we are finalizing our policy to include in Addendum B to the CY 2011 OPPS/ASC final rule with comment period the new Category I and III CPT codes effective January 1, 2011 (including those Category I vaccine and Category III CPT codes that were released by the AMA in July 2010) that would be incorporated in the January 2011 OPPS quarterly update CR and the new Level II HCPCS codes, effective October 1, 2010, or January 1, 2011, that would be released by CMS in its October 2010 and January 2011 OPPS quarterly update CRs.

3. Temporary HCPCS Codes for 2010–2011 Seasonal Influenza Vaccines

In Addendum B of the CY 2011 OPPS/ASC proposed rule (75 FR 46662), CPT code 90658 (Influenza virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use) was assigned to status indicator "L" to indicate that the code is not paid under the OPPS; rather, it is paid at a reasonable cost that is not subject to a deductible or coinsurance. Under the Medicare ASP pricing methodology, CPT code 90658 currently includes multiple brand name products. For influenza vaccines, the payment limit is 95 percent of the AWP of the lowest brand-name product within each billing code. We understand that the production capacity and supply of the lowest priced brand-name influenza vaccine product will not meet the program demands of the Medicare population for the 2010–2011 influenza season. Because of this patient access problem, we believe it necessary to establish separate HCPCS codes for the individual brand products currently associated with CPT code 90658. Thus, Medicare has established five HCPCS Q-codes to identify the individual influenza products that are reported with CPT code 90658. The specific list of HCPCS Q-codes can be found in Table 21 below CY 2011. Because the HCPC Q-codes will be recognized by Medicare, CPT code 90658 will be assigned to status indicator "E" to indicate that the code is not recognized under the hospital OPPS. Hospitals are advised to report the influenza HCPCS Q-codes rather than CPT code 90658 for CY 2011. These codes have been included in the HCPCS file with an added date of January 1, 2011, but the HCPCS codes will be implemented effective October 1, 2010. That is, CPT code 90658 is assigned to status indicator "E" effective October 1, 2010, and HCPCS Q-codes Q2035, Q2036, Q2037, Q2038, and Q2039 are assigned to status indicator "L" effective January 1, 2011. Table 21 below contains the final CY 2011 status indicators for CPT code 90658 and HCPCS Q-codes Q2035, Q2036, Q2037, Q2038, and Q2039.

TABLE 21—INFLUENZA HCPCS Q-CODES FOR CY 2011

HCPCS	Short descriptor	Long descriptor	Final CY 2011 SI
90658	Flu vaccine, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use.	E
Q2035	Afluria vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria).	L
Q2036	Flulaval vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval).	L
Q2037	Fluvirin vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin).	L
Q2038	Fluzone vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone).	L
Q2039	NOS flu vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified).	L

B. OPPS Changes—Variations Within APCs

1. Background

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

We have packaged into payment for each procedure or service within an APC group the costs associated with those items or services that are directly related to, and supportive of, performing the main independent procedures or furnishing the services. Therefore, we do not make separate payment for these packaged items or services. For example, packaged items and services include: (1) Use of an operating, treatment, or procedure room; (2) use of a recovery room; (3) observation services; (4) anesthesia; (5) medical/surgical supplies; (6) pharmaceuticals (other than those for which separate payment may be allowed under the provisions discussed in section V. of this final rule with comment period); (7) incidental services such as venipuncture; and (8) guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, and

contrast media. Further discussion of packaged services is included in section II.A.3. of this final rule with comment period.

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

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

Section 1833(t)(9)(A) of the Act requires the Secretary to review and revise the groups, the relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors; the Act further requires us to repeat this process on a basis that is not less often than annually. Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA, also requires the Secretary, beginning in CY 2001, to consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the APC groups and the relative payment weights (the APC Panel recommendations for specific services for the CY 2011 OPPS and our responses to them are discussed in the relevant specific sections throughout this final rule with comment period).

Finally, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median cost (or mean cost as elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the same group (referred to as the "2 times rule"). We use the median cost of the item or service in implementing this provision. The statute authorizes the Secretary to make exceptions to the 2 times rule in unusual cases, such as low-volume items and services (but the Secretary may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act).

2. Application of the 2 Times Rule

In accordance with section 1833(t)(2) of the Act and § 419.31 of the regulations, we annually review the items and services within an APC group to determine, with respect to comparability of the use of resources, if the median cost of the highest cost item or service within an APC group is more than 2 times greater than the median of the lowest cost item or service within that same group. In making this determination, we consider only those HCPCS codes that are significant based on the number of claims. That is, we consider only those HCPCS codes whose claim data reflect more than 1,000 singles, or if less than 1,000 singles, at least those HCPCS codes with more than 99 singles and represent more than 2 percent of the claims for a given APC (74 FR 60436). In the CY 2011 OPPS/ASC proposed rule (75 FR 46247), we proposed to make exceptions to this limit on the variation of costs within each APC group in unusual cases, such as low-volume items and services for CY 2011.

During the APC Panel's February 2010 meeting, we presented median cost and utilization data for services furnished during the period of January 1, 2009 through September 30, 2009, about which we had concerns or about which the public had raised concerns regarding their APC assignments, status indicator assignments, or payment rates. The discussions of most service-specific issues, the APC Panel recommendations, if any, and our proposals for CY 2011 were contained mainly in sections III.C. and III.D. of the proposed rule and are included in the same sections of this final rule with comment period.

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

We received many public comments regarding the proposed APC and status indicator assignments for CY 2011 for specific HCPCS codes. These public comments are discussed mainly in sections III.C. and III.D. of this final rule with comment period, and the final action for CY 2011 related to each HCPCS code is noted in those sections.

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

3. Exceptions to the 2 Times Rule

As discussed earlier, we may make exceptions to the 2 times limit on the variation of costs within each APC group in unusual cases such as low-volume items and services. Taking into account the APC changes that we proposed for CY 2011 based on the APC Panel recommendations that were discussed mainly in sections III.C. and III.D. of the proposed rule, the other

proposed changes to status indicators and APC assignments as identified in Addendum B to the proposed rule, and the use of CY 2009 claims data to calculate the median costs of procedures classified in the APCs, we reviewed all the APCs to determine which APCs would not satisfy the 2 times rule. We used the following criteria to decide whether to propose exceptions to the 2 times rule for affected APCs:

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

For a detailed discussion of these criteria, we refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18457 and 18458). Table 16 of the proposed rule listed 17 APCs that we proposed to exempt from the 2 times rule for CY 2011 based on the criteria cited above (75 FR 46248).

We did not receive any general public comments related to the list of proposed exceptions to the 2 times rule. We received a number of specific public comments about some of the procedures assigned to APCs that we proposed to make exempt from the 2 times rule for CY 2011. Those public comments are discussed elsewhere in this preamble, and can be found in sections related to the types of procedures that were the subjects of the public comments.

For the proposed rule, the list of 17 APCs that appeared in Table 16 of the CY 2011 OPPS/ASC proposed rule (75 FR 46248) that were exempted from the 2 times rule were based on data from January 1, 2009, through September 30, 2009. For this final rule with comment period, we used claims data for dates of service between January 1, 2009, and December 31, 2009, that were processed on or before June 30, 2010, and updated CCRs, if available. Thus, after responding to all of the public comments on the CY 2010 OPPS/ASC proposed rule and making changes to APC assignments based on those comments, we analyzed the CY 2009 claims data used for this final rule with comment period to identify the APCs with 2 times violations. Based on the final rule CY 2009 claims data, we found 22 APCs with 2 times rule violations, which is a cumulative increase of 5 APCs from the proposed rule. We applied the criteria as described earlier to identify the APCs that are exceptions to the 2 times rule for CY 2010, and identified 10 APCs that meet the criteria for exception to the 2 times rule for this final rule with comment period, but that did not meet those criteria using proposed rule data: APC 0060 (Manipulation Therapy); APC 0076 (Level I Endoscopy Lower Airway); APC 0083 (Coronary or Non Coronary Angioplasty and Percutaneous Valvuloplasty), APC 0133 (Level I Skin Repair); APC 0203 (Level IV Nerve Injections); APC 0304 (Level I Therapeutic Radiation Treatment Preparation); APC 0341 (Skin Tests); APC 0343 (Level III Pathology); APC 0433 (Level II Pathology); and APC 0607 (Level 4 Hospital Clinic Visits). These APC exceptions are listed in Table 22 below. For this final rule with comment period, we also determined that there are 5 APCs that no longer violate the 2 times rule: APC 0051 (Level III Musculoskeletal Procedures Except Hand and Foot); APC 0138 (Level II Closed Treatment Fracture Finger/Toe/Trunk); APC 0173 (Level II Partial Hospitalization (4 or more services)); APC 0325 (Group Psychotherapy); and APC 0344 (Level IV Pathology). We have not included in this count those APCs where a 2 times violation is not a relevant concept, such as APC 0375 (Ancillary Outpatient Services When Patient Expires), with an APC median cost set based on multiple procedure claims. As a result, we have identified only final APCs, including those with criteria-based median costs, such as device-dependent APCs, with 2 times violations. Table 22 below lists 22 APCs that we are exempting from the 2 times rule for CY 2011 based on the criteria cited above and a review of updated claims data.

For cases in which a recommendation by the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the APC Panel's recommendation because those recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the CY 2009 claims data used to determine the APC payment rates that we are finalizing for CY 2011. The median costs for hospital outpatient services for these and all other APCs that were used in the development of this final rule with comment period can be found on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/01_overview.asp.*

TABLE 22—FINAL APC EXCEPTIONS TO THE 2 TIMES RULE FOR CY 2011

CY 2011 APC	CY 2011 APC title
0057	Bunion Procedures.
0058	Level I Strapping and Cast Application.
0060	Manipulation Therapy.
0076	Level I Endoscopy Lower Airway.
0080	Diagnostic Cardiac Catheterization.
0083	Coronary and Noncoronary Angioplasty and Percutaneous Valvuloplasty.
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices.
0133	Level I Skin Repair.
0142	Small Intestine Endoscopy.
0203	Level IV Nerve Injections.
0235	Level I Posterior Segment Eye Procedures.
0245	Level I Cataract Procedures without IOL Insert.
0303	Treatment Device Construction.
0304	Level I Therapeutic Radiation Treatment Preparation.
0340	Minor Ancillary Procedures.
0341	Skin Tests.
0343	Level III Pathology.
0432	Health and Behavior Services.
0433	Level II Pathology.
0604	Level 1 Hospital Clinic Visits.
0607	Level 4 Hospital Clinic Visits.
0664	Level I Proton Beam Radiation Therapy.

C. New Technology APCs

1. Background

In the November 30, 2001 final rule (66 FR 59903), we finalized changes to the time period a service was eligible for payment under a New Technology APC. Beginning in CY 2002, we retain services within New Technology APC groups until we gather sufficient claims data to enable us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 2 years if sufficient data upon which to base a decision for reassignment have not been collected.

We note that the cost bands for New Technology APCs range from $0 to $50 in increments of $10, from $50 to $100 in increments of $50, from $100 to $2,000 in increments of $100, and from $2,000 to $10,000 in increments of $500. These cost bands identify the APCs to which new technology procedures and services with estimated service costs that fall within those cost bands are assigned under the OPPS. Payment for each APC is made at the mid-point of the APC's assigned cost band. For example, payment for New Technology APC 1507 (New Technology—Level VII

($500–$600)) is made at $550. Currently, there are 82 New Technology APCs, ranging from the lowest cost band assigned to APC 1491 (New Technology—Level IA ($0–$10)) through the highest cost band assigned to APC 1574 (New Technology—Level XXXVII ($9,500–$10,000). In CY 2004 (68 FR 63416), we last restructured the New Technology APCs to make the cost intervals more consistent across payment levels and refined the cost bands for these APCs to retain two parallel sets of New Technology APCs, one set with a status indicator of "S"' (Significant Procedures, Not Discounted when Multiple. Paid under OPPS; separate APC payment) and the other set with a status indicator of "T" (Significant Procedure, Multiple Reduction Applies. Paid under OPPS; separate APC payment). These current New Technology APC configurations allow us to price new technology services more appropriately and consistently.

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

Under the OPPS, one of our goals is to make payments that are appropriate for the services that are necessary for the treatment of Medicare beneficiaries. The OPPS, like other Medicare payment systems, is budget neutral and increases are limited to the hospital inpatient market basket increase. We believe that our payment rates generally reflect the costs that are associated with providing care to Medicare beneficiaries in cost efficient settings, and we believe that our rates are adequate to ensure access to services.

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

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

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

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

Consistent with our current policy, in the CY 2011 OPPS/ASC proposed rule (75 FR 46249), we proposed for CY 2011 to retain services within New Technology APC groups until we gather sufficient data to enable us to assign the service to a clinically appropriate APC. The flexibility associated with this policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 2 years if sufficient data upon which to base a decision for reassignment have not been collected. Table 17 of the proposed rule listed the HCPCS codes and associated status indicators that we proposed to reassign from a New Technology APC to a clinically appropriate APC or to a different New Technology APC for CY 2011.

We note that, for CY 2010, there are four services described by four HCPCS G-codes receiving payment through a New Technology APC. Specifically, HCPCS code G0416 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1–20 specimens) is assigned to New Technology APC 1505 (New Technology—Level V ($300–$400)); HCPCS code G0417 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21–40 specimens) is assigned to New Technology APC 1507 (New Technology—Level VII ($500–$600)); HCPCS code G0418 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41–60 specimens) is assigned to New Technology APC 1511 (New Technology—Level XI ($900–$1,000)); and HCPCS code G0419 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens), is assigned to New Technology APC 1513 (New Technology—Level XIII ($1,100–$1,200)).

In the CY 2011 OPPS/ASC proposed rule (75 FR 46249), we proposed to reassign HCPCS code G0416 from New Technology APC 1505 to clinical APC 0661 (Level V Pathology), and HCPCS code G0417 from New Technology APC 1507 (New Technology–Level VII ($500 to $600)) to New Technology APC 1506 (New Technology—Level VI ($400–$500)). Based on our claims data used for CY 2011 rate setting, as well as clinical characteristics, we believed that HCPCS code G0416 is comparable clinically and with respect to the use of resources as other pathology services currently assigned to APC 0661. Further, we believed that HCPCS code G0417 is more appropriately placed in New Technology APC 1506 based on the median cost data for the CY 2011 ratesetting and based on its clinical and

resource similarities to procedures currently in APC 1506.

We did not receive any public comments on the APC reassignments of HCPCS codes G0416 and G0417. Therefore, for the reasons explained above, we are finalizing our proposal, without modification, to assign HCPCS code G0416 to APC 0616, which has a final CY 2011 APC median cost of approximately $149, and to assign HCPCS code G0417 to APC 1506, which has a final CY 2011 APC median cost of approximately $489. Table 23 below lists the HCPCS codes and associated status indicators that we are reassigning from a New Technology APC to a clinically appropriate APC or to a different New Technology APC for CY 2011.

For CY 2011, we also proposed to continue the New Technology APC assignments for HCPCS codes G0418 and G0419 based on our understanding of the clinical and cost characteristics of the procedures described by these HCPCS codes. As we stated in the CY 2011 OPPS/ASC proposed rule (75 FR 46249), we do not believe we have enough claims data to assign these codes to a different APC. While we believed that these services will always be low volume, given the number of specimens being collected, we believed that we should continue the New Technology payments for HCPCS codes G0418 and G0419 for another year to see if more claims data become available. Specifically, we proposed to continue to assign HCPCS code G0418 to New Technology APC 1511 (New Technology—Level XI ($900–$1,000)) and HCPCS code G0419 to New Technology APC 1513 (New Technology—Level XIII ($1,100–$1,200)).

We did not receive any public comments on the continuation of the APC assignments of HCPCS code G0418 and G0419. Therefore, for the reasons explained above, we are finalizing our proposal, without modification, to continue to assign HCPCS code G0418 to APC 1511, and to continue to assign HCPCS code G0419 to APC 1513. The final CY 2011 payment rates for HCPCS codes G048 and G0419 can be found in Addendum B of this final rule with comment period.

TABLE 23—CY 2011 REASSIGNMENT OF PROCEDURES ASSIGNED TO NEW TECHNOLOGY APCS IN CY 2010

CY 2010 HCPCS code	CY 2010 Short descriptor	CY 2010 SI	CY 2010 APC	Final CY 2011 SI	Final CY 2011 APC
G0416	Sat biopsy prostate 1–20 spc	S	1505	X	0661
G0417	Sat biopsy prostate 21–40	S	1507	S	1506

D. OPPS APC-Specific Policies

1. Cardiovascular Services

a. Cardiovascular Telemetry (APC 0209)

For CY 2011, we proposed to continue to assign CPT code 93229 (Wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG-triggered and patient-selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed transmission of daily and emergent data reports) to APC 0209 (Level II Extended EEG, Sleep, and Cardiovascular Studies), with a proposed payment rate of approximately $782.

Comment: Some commenters recommended that CMS assign status indicator "A" (Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS) to CPT code 93229 in order to make this service nonpayable under the OPPS for CY 2011. The commenters stated that there are currently no hospitals that can provide the type of constant monitoring that the service described by CPT code 93229 requires. For this reason, according to the commenters, any claims submitted for CPT code 93229 by hospitals are incorrectly coded. The commenters suggested that, if CMS chose not to adopt their recommendation and instead chose to continue recognizing CPT code 93229 as payable under the OPPS, CMS reconsider the proposed assignment of the service to APC 0209. According to the commenters, the service described by CPT code 93229 is not similar, clinically or in terms of resource utilization, to the other procedures assigned to APC 0209, in particular, the polysomnography procedures described by CPT codes 95810 (Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist) and 95811 (Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist), which are the most commonly reported procedures in APC 0209 with the highest number of single claims contributing to the APC's median cost. The commenters urged CMS to assign CPT code 93229 to the New Technology APC 1513 (New Technology—Level XIII ($1,100–$1,200)), with a proposed payment rate of approximately $1,150. The commenters stated that, if any hospitals were to provide the remote cardiac monitoring service described by CPT code 93229, the proposed payment rate for APC 0209 would be less than hospitals' costs for providing this service.

Response: We do not agree with the commenters that we should assign status indicator "A" to CPT code 93229 in order to make the service nonpayable under the OPPS for CY 2011. We typically recognize, for OPPS payment purposes, HCPCS codes describing services that could be covered by Medicare when provided to hospital outpatients, regardless of whether, as the commenters indicated, those services are actually being provided by hospitals at the time the OPPS/ASC final rule with comment period for the upcoming year is issued. We believe that CPT code 93229 describes a diagnostic study that could be provided to Medicare beneficiaries in the hospital outpatient setting and, therefore, could be covered by Medicare. We also do not agree with the commenters' statement that there are currently no hospitals that can provide the type of constant monitoring that the service described by CPT code 93229 requires. Our ratesetting methodology is based on claims submitted by hospitals, and our final rule claims data show 103 single claims and 114 total claims for this service. Based on these claims data, we calculated a final median cost for CPT code 93229 of approximately $287. (We note that placement of CPT code 93229 in APC 0209 with higher median cost procedures does not violate the 2 times rule because this service is a low

volume procedure relative to the other procedures in APC 0209.) As to whether these claims are miscoded, it is generally not our policy to judge the accuracy of hospital coding and charging for purposes of ratesetting. New Technology APCs are designed to allow us to provide appropriate and consistent payment for designated new procedures that are not yet reflected in our claims data (74 FR 60438). Because we already have sufficient claims data for CPT code 93229 to assign it to a clinically appropriate APC, it would be inappropriate to move it to the New Technology APC 1513.

As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60441), we also continue to believe the service described by CPT code 93229 is similar, clinically and in terms of resource utilization, to the other procedures assigned to APC 0209 for CY 2011. For example, similar to the remote cardiac monitoring service described by CPT code 93229, the polysomnography procedures described by CPT codes 95810 and 95811 involve continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters, with attendance by a technologist.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to assign CPT code 93229 to APC 0209, with a final CY 2011 APC median cost of approximately $772.

b. Myocardial Positron Emission Tomography (PET) Imaging (APC 0307)

For CY 2011, we proposed to assign CPT codes 78459 (Myocardial imaging, positron emission tomography (PET), metabolic evaluation), 78491 (Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress), and 78492 (Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress) to APC 0307 (Myocardial Position Emission Tomography (PET) Imaging), with a proposed median cost of approximately $1,121. For CY 2010, APC 0307 has a national unadjusted payment rate of approximately $1,433 based on a CY 2010 OPPS final rule median cost of approximately $1,420. At its August 2010 meeting, the APC Panel recommended that CMS investigate and report at a future Panel meeting on the reason for the decline in median cost for APC 0307 from the CY 2010 OPPS to the proposed CY 2011 OPPS.

Comment: Commenters objected to the proposed decrease in the payment rate for myocardial PET under APC 0307. They indicated that there is increasing interest in the service due to shortages of radioisotopes required for SPECT myocardial perfusion imaging as well as developing evidence favoring use of myocardial PET imaging and growing expertise in the use of myocardial PET imaging. The commenters were concerned that the volatility of the payment rates from one year to the next at least since 2006, and the reduction in the payment rate from $1,433 in CY 2010 to the $1,099 proposed payment rate for APC 0307 for CY 2011 will make it hard for hospitals to plan and budget for the forthcoming year. The commenters urged CMS to validate the estimated costs on the CY 2009 claims data for the limited numbers of hospitals reporting CPT codes 78459, 78491, and 78492 (APC 0307) to determine the reason for the proposed change in payment. The commenters believed that the proposed payment rate is a result of the service largely being furnished by a relatively small number of facilities that may be driving the observed reduction. One commenter stated that hospitals do not always align the costs and charges for the service properly in their accounts and, therefore, the CCRs that result from the cost reports understate the cost of the services. Another commenter believed that hospitals with disproportionately low CCRs may have been disproportionately included in the single bills (compared to the total volume of service that they furnish). This commenter also stated that the median cost for single scans, represented by CPT code 78491 has been higher than the median cost for multiple scans, represented by CPT code 78492 in 2007, 2009 and 2010 and that the evidence indicates that the data on which CMS is basing the payment rate are flawed.

One commenter urged CMS to average the median costs over a 4-year period to provide stability to the payment rates or to assign CPT codes 78459, 78491, and 78492 to New Technology APC Level XIV so that the services would be paid $1,250 for CY 2011. Another commenter stated that payment under the MPFS for these services is carrier priced and, therefore, has remained stable over the years. The commenter asked that CMS use the payment rates being paid under the MPFS as the basis for payment under the OPPS for these services. One commenter asked that CMS eliminate all single bills from hospitals that have a CCR that is less than 0.2 for the calculation of costs for myocardial PET services and that CMS establish a cost center and CCR specific to PET that would be used to reduce charges for PET to costs. Several commenters asked that CMS limit to 10 percent the amount of decrease in the median cost for CY 2011 compared to CY 2010 and slowly phase in any reduction beyond 10 percent. Other commenters asked that CMS set the relative weight for payment for APC 0307 using the mean cost rather than the median cost.

Response: To determine the reason that the median cost declined from CY 2010 to CY 2011, we examined the data for the single bills that were used to set the median cost for APC 0307 for CY 2010, the proposed CY 2011 proposed rule, and the CY 2011 final rule with comment period, and we determined that there are multiple reasons that the median cost for APC 0307 declined from CY 2010 to CY 2011. In general, when we looked the charges and the CCRs for CPT codes 78459, 78491, and 78492 in APC 0307, we found that the charges either stayed the same or declined, that the CCRs used to estimate cost from charges for these codes declined, and that the cost of HCPCS code A9555 (Rb82 rubidium), the radiopharmaceutical that is used in a myocardial PET scan, also declined. Specifically, the median of the line item charge for CPT code 78492, the highest volume code in APC 0307 (comprising 96 percent of single bills used to establish the median cost for APC 0307 in the CY 2011 final rule claims data) remained virtually unchanged between the CY 2010 final rule claims data ($3,859.00) and the CY 2011 final rule claims data ($3,858.75). However, the median hospital CCR applicable to the line item charge for CPT code 78492, largely derived from cost center 4100 (Radiology-Diagnostic), declined from 0.2342 in the CY 2010 HCRIS data to 0.1708 in the CY 2011 final rule claims data. Moreover, the estimated per day cost of rubidium, which is reported with 95 percent of claims for CPT code 78492, declined from $418.05 per day in the CY 2010 final rule claims data to $330.06 in the CY 2011 final rule claims data. The hospital CCR used to estimate costs from charges for rubidium also is based on cost center 4100. The other two myocardial PET codes, CPT codes 78459 and 78491, show similar patterns of charges and CCRs, although they account for a much lower percent of single bills than CPT code 78492, which causes them to have much less influence on the median cost for APC 0307. We believe that the absence of increase in the line item charge, the significant decline in the applicable CCRs for CPT code 78492, and the significant decline in the estimated cost

of rubidium combine to explain the reduction in the median cost for APC 0307 for CY 2011 compared to CY 2010. We also used a substantial volume of single bills for the APC (3,638 single bills out of 5,732 total frequency or approximately 64 percent of the claims for services in APC 0307). In addition, as is our standard practice, we used the most recently submitted cost reports to calculate the CCRs (largely CCRs for cost center 4100 that are applied to the charges for these imaging services) to estimate the cost.

We agree that the modest number of hospitals that furnish the service (50 in the CY 2010 final rule claims data and 61 in the CY 2011 final rule claims data) and the addition of claims from 11 hospitals that reported the service for the first time in CY 2009 may have some bearing on the volatility in the median costs, and we will continue to monitor these data in the future. However, it is also possible that hospitals are becoming more efficient and that the cost of the service is declining as it becomes better established. Our standard methodology of estimating costs from charges and creating single claims with a unique resource cost for individual services resulted in the use of 64 percent of the claims for services in APC 0307 for ratesetting; and, we used the most current claims and cost report data that are available for the estimation of the cost of the service. With regard to the comment that the estimated cost for CPT code 78491 has been higher than CPT code 78492 in past years, the low sample size and differences in the mix of hospitals reporting these codes likely accounts for this observation and do not suggest the data are flawed. We also note that any difference in estimated cost between single and multiple studies would not impact the payment rate as claims for CPT code 78492 drive the estimated median cost for this APC.

Based on our review of the claim charge data and cost report data, we believe our estimated cost data for the services in APC 0307 are accurate and, therefore, will not adopt an alternative methodology, such as commenters requests to limit CCRs to those at 0.2 or above, calculating a rolling average based on 4 years of past medians, assigning the codes to a new technology APC, limiting the decline in the median cost to 10 percent, setting the weight on the mean cost rather than the median cost, or setting the payment rate at the amount paid to physicians for the service. Similarly, we do not believe that the CCRs that are applied to the charges for myocardial PET result in flawed estimated costs for the service and that a cost center specific to PET services is necessary to provide valid CCRs for PET services.

After consideration of the public comments we received and examination of the reasons for the decline in the median cost for APC 0307, we are not making any of the adjustments to the median cost that commenters request because we believe that the data on which the median is calculated are valid and that the median is accurate. Therefore we are finalizing a payment rate for APC 0307 for CY 2011 based on the CY 2011 OPPS final rule median cost of approximately $1,096. We are accepting the APC Panel's recommendation and will report the findings of our investigation into the reason for the decline in median cost for APC 0307 from the CY 2010 OPPS to the proposed CY 2011 OPPS at the winter 2011 APC Panel meeting.

c. Cardiovascular Computed Tomography (CCT) (APCs 0340 and 0383)

The AMA CPT Editorial Panel created the following new codes for Cardiovascular Computed Tomography (CCT) services, effective January 1, 2010: CPT codes 75571 (Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium), 75572 (Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)), 75573 (Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)), and 75574 (Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed). For CY 2010, we assigned CPT code 75571 to APC 0340 (Minor Ancillary Procedures). For CY 2010, we also assigned CPT codes 75572, 75573, and 75574 to APC 0383 (Cardiac Computed Tomographic Imaging). For CY 2011, we proposed to maintain these APC assignments, with a proposed rule median cost for APC 0340 of approximately $48 and a proposed rule median cost for APC 0383 of approximately $263.

Comment: One commenter urged CMS to consider using data sources in addition to our claims and cost report data to establish the basis for payment for CCT because the commenter believed that hospitals have reported incorrect or incomplete data for CY 2009 for CCT services. The commenter stated that the incorrect data are due to unfamiliarity or misinterpretation of Category III CPT codes that were used prior to CY 2010, and are reflected in the charges on the claims for services in CY 2009 on which the median costs for CY 2011 will be based. The commenter stated that it is developing a data collection to present to CMS to substantiate that CCT services are more costly than the CY 2009 data that CMS used. The commenter urged CMS to be open to accepting new data.

Response: We have no reason to believe that the median costs we have calculated for CPT codes 75571, 75572, 75573, and 75574 do not reflect valid estimates of the cost of these services. We proposed to continue to assign CPT code 75571 to APC 0340, which had a CY 2011 proposed rule APC median cost of approximately $46. We also proposed to continue to assign CPT codes 75572, 75573, and 75574 to APC 0383, which had a proposed rule CY 2011 APC median cost of approximately $254. Because CPT codes 75571, 75572, 75573, and 75574 are all new for CY 2010, we do not have CY 2009 claims data for these codes for CY 2011 OPPS ratesetting. However, we assigned them to APCs 0340 and 0383 based on what we believe to be their clinical and resource similarity to the other services in the APC, for which we have claims data.

Concerning the request that we review external data that may be provided in the future, we do review data that the public wishes to share with us. However, because the OPPS is a budget neutral relative weight based system, we believe that it is critical that the same source of data and the same cost estimation process be used to establish the median costs for services paid under the OPPS so that the payment rates derived from the median costs are correct in relativity to one another.

After considering the public comments we received and reviewing our updated CY 2009 claims data, we are continuing to maintain the assignment of CPT code 75571 to APC 0340 for CY 2011, for which we have calculated a final rule median cost of approximately $46. We also are maintaining the assignment of CPT codes 75572, 75573, and 75574 to APC 0383, for which we have calculated a

final rule median cost of approximately $254 for CY 2011.

d. Multifunction Cardiogram (APC 0340)

For CY 2011, we proposed to continue to assign Category III CPT code 0206T (Algorithmic analysis, remote, of electrocardiographic-derived data with computer probability assessment, including report) to APC 0340 (Minor Ancillary Procedures), with a proposed payment rate of approximately $47.

Comment: One commenter defined the procedure described by CPT code 0206T as a multifunction cardiogram. The commenter stated that CMS should reconsider the proposed assignment of CPT code 0206T to APC 0340 because it is not similar, clinically or in terms of resource utilization, to the other procedures assigned to APC 0340. The commenter stated that the majority of the other procedures in APC 0340 are minor office procedures that are quickly done and do not require data transmission or analysis. According to the commenter, the complex data obtained and analyzed by the multifunction cardiogram is comparable to the data obtained and analyzed during cardiac stress tests or electrocardiograms, and serve as an alternative to radionuclide stress testing in the diagnosis of coronary artery disease. Based on the use of the multifunction cardiogram and the data it generates, the commenter believed that the procedure described by CPT code 0206T is most similar clinically to the procedures assigned to APC 0100 (Cardiac Stress Tests), which had a proposed payment rate of approximately $180. However, in terms of resource utilization, the commenter claimed that payment for the multifunction cardiogram should be $75 more than the payment for APC 0100. The commenter pointed out that CPT code 0206T was new for CY 2010, and, therefore, no CY 2009 claims data are available for CY 2011 OPPS ratesetting. The commenter described a multifunction cardiogram as a non-traditional systems analysis tool that creates a mathematical model for the detection of myocardial ischemia, and argued that this tool represents a completely new technology. The commenter recommended that CMS reassign CPT code 0206T to APC 1504 (New Technology—Level IV ($200–$300)).

Response: We appreciate the commenter's submission of this clinical information for the procedure described by Category III CPT code 0206T for our review. As a new Category III CPT code for CY 2010, we do not yet have hospital claims data for the procedure. Category III CPT codes are temporary codes that describe emerging technology, procedures, and services, and they are created by the AMA to allow for data collection for new services or procedures. Under the OPPS, we generally assign a payment rate to a new Category III CPT code based on input from a variety of sources, including but not limited to, review of resource costs and clinical homogeneity of the service to existing procedures, information from specialty societies, input from CMS medical advisors, and other information available to us. Based on our review of the clinical characteristics of CPT code 0206T and the information provided by the commenter, we do not believe that we have sufficient clinical or cost information to justify a reassignment to a different APC at this time. However, the APC Panel Subcommittee for APC Groups and Status Indicator (SI) Assignments provides substantive advice to us on the correct assignment of services to APCs, and the Subcommittee members bring expertise and experience to their review of clinical issues. Therefore, we will review the procedure described by the commenter with the APC Panel's Subcommittee for APC Groups and Status Indicator (SI) Assignments at the winter 2011 APC Panel meeting.

After review of the public comment we received, we are finalizing our CY 2011 proposal, without modification, to continue to assign Category III CPT code 0206T to APC 0340. As we indicated earlier, we also will review the APC assignment of Category III CPT code 0206T with the APC Panel's Subcommittee for APC Groups and SI Assignments at the winter 2011 APC Panel meeting.

e. Unlisted Vascular Surgery Procedure (APC 0624)

For CY 2011, we proposed to continue to assign CPT code 37799 (Unlisted procedure, vascular surgery) to APC 0624 (Phlebotomy and Minor Vascular Access Device Procedures), which had a proposed payment rate of approximately $43.

Comment: One commenter requested that CMS reassign CPT code 37799 from APC 0624 to APC 0103 (Miscellaneous Vascular Procedures), which had a proposed CY 2011 OPPS payment rate of approximately $1,309. The commenter stated that CPT code 37799 is most clinically related to the services assigned to APC 0103. The commenter further stated that continuing to assign CPT code 37799 to APC 0624 would limit patient access to new technology and clinically advanced procedures.

Response: As a matter of policy, which we have stated previously in the OPPS final rules with comment period since 2005 (69 FR 65724 through 65725), HCPCS codes that are unlisted procedures, not otherwise classified, or not otherwise specified codes, are assigned to the lowest level APC that is appropriate to the clinical nature of the service. We also do not consider the costs of these services in assessing APCs for 2 times rule violations. We do not believe that the assignment of CPT code 37799 to APC 0103, as the commenter suggested, would be consistent with our policy to assign HCPCS codes for unlisted procedures to the lowest level APC that is appropriate to the clinical nature of the service. Because unlisted codes do not describe any specific service, we believe that assigning them to the lowest level APC is appropriate under the hospital OPPS. Furthermore, we cannot assess whether the procedure described by CPT code 37799 is similar to procedures in APC 0103 because the CPT code does not describe any particular service. We note that the CPT instruction that appears underneath CPT code 36592 (Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified) refers to the use of unlisted CPT code 37799 for blood collection from an established arterial catheter, a very low intensity service. We also note that we would assign a service or procedure to a more appropriate APC once it is assigned to a specific CPT or HCPCS code.

After consideration of the public comment we received, we are finalizing our proposal, without modification, to continue to assign CPT code 37799 to APC 0624, which has a final CY 2011 APC median cost of approximately $43.

f. Implantable Loop Recorder Monitoring (APC 0691)

For CY 2011, we proposed to assign CPT code 93299 (Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results) to APC 0691 (Level III Electronic Analysis of Devices), with a proposed payment rate of approximately $169.

Comment: Some commenters acknowledged that APC 0691 is a reasonable placement for CPT code 93299 based on its proposed rule median cost of approximately $274, but questioned the accuracy of the CY 2009 proposed rule claims data that CMS used to calculate the median cost. One

commenter stated that claims data were available for this service for the first time for CY 2011 ratesetting and argued that the proposed rule median cost for CPT code is too high, pointing out that the average physician charge for the same service in CY 2009 was only $42.87. In addition, the commenter stated that the OPPS median cost for a similar service, described by CPT 93296 (Interrogation device evaluation(s), (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results) is significantly lower than the median cost for CPT code 93299. Therefore, the commenter suggested that CPT code 93299 be assigned to APC 0690 (Level I, Electronic Analysis of Devices), the same APC to which CPT code 93296 is assigned.

Response: The commenters mistakenly cited $274 as the proposed rule median cost for CPT code 93299 for CY 2011. The proposed rule "median" cost for CPT code 93299 was approximately $184, while the proposed rule "mean" cost for CPT code 93299 was approximately $274. We understand that the commenters are concerned about differences in costs for services provided in different settings (HOPDs versus physicians' offices) when the same services are provided to Medicare beneficiaries. Even though both settings use the standard CPT code set, the costs of providing these services in one setting may not be the same as the costs in another setting. The OPPS and the MPFS are fundamentally different payment systems with essential differences in their payment policies. Specifically, the OPPS is a prospective payment system, based on the concept of paying for groups of services that share clinical and resource characteristics. Payment is made under the OPPS according to prospectively established payment rates that are related to the relative costs of hospital resources for services, as calculated from claims data and Medicare cost reports. The MPFS is a fee schedule that generally provides separate payment for each individual service, reflecting the expected typical inputs into these services. The OPPS methodology allows hospitals to actively contribute on an ongoing basis to the ratesetting process through its annual updates and to influence future payment rates for services by submitting correctly coded and accurately priced claims for the services they provide. According to this methodology, it is generally not our policy to judge the accuracy of hospital coding and charging for purposes of ratesetting. The CY 2011 final rule median cost for CPT code 93299 is approximately $180, calculated from 558 single claims. Therefore, we do not agree with commenters that we should assign this procedure to APC 0690, which has a final rule median cost of only $35.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to continue to assign CPT code 93299 to APC 0691, with a final CY 2011 APC median cost of approximately $165.

2. Gastrointestinal (GI) Services: Upper GI Endoscopy (APCs 0141, 0384, and 0422)

For CY 2011, we proposed to reassign four upper gastrointestinal endoscopy CPT codes from APC 0141 (Level I Upper GI Procedures) to APC 0422 (Level II Upper GI Procedures). Specifically, we proposed to reassign CPT codes 43216 (Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery), 43242 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate), 43510 Gastrotomy; with esophageal dilation and insertion of permanent intraluminal tube (e.g., celestin or mousseaux-barbin)), and 43870 (Closure of gastrostomy, surgical) from APC 0141, with a proposed payment rate of approximately $606, to APC 0422, with a proposed payment rate of approximately $1,113.

For CY 2011, we proposed to continue to assign CPT code 43240 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst) to APC 0141, with a proposed payment rate of approximately $600. We also proposed to continue to assign CPT code 43228 (Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique) to APC 0422 with a proposed payment rate of approximately $1,113.

Comment: Several commenters disagreed with the reassignment of CPT codes 43216, 43242, 43510, and 43870 from APC 0141 to APC 0422 because, they stated, these procedures are similar to those services that will continue to be assigned to APC 0141, specifically CPT codes 43231 (Esophagoscopy, rigid or flexible; with endoscopic ultrasound examination), 43232 (Esophagoscopy, rigid or flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)), 43237 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination limited to the esophagus), 43238 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)), and 43259 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate). The commenters stated that the reassignment to APC 0422 does not maintain the clinical homogeneity and resource characteristics of these services.

Response: Section 1833(t)(9)(A) of the Act requires the Secretary to review and revise the groups, the relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors; the Act further requires us to repeat this process on a basis that is not less often than annually. As such, we review, on an annual basis, all APC assignments for both general appropriateness and for violations of the 2 times rule and, when necessary, reassign CPT codes to more appropriate APCs. Although there was no violation of the 2 times rule in APC 0141, based on our review of the CY 2009 proposed rule claims data used for ratesetting, we believed that a change in APC assignment was necessary for CPT codes 43216, 43242, 43510, and 43870. For CY 2011, the proposed median cost for APC 0141 was approximately $618. However, the median cost for CPT codes 43216, 43242, 43510, and 43870 were significantly higher. Specifically, CPT code 43216 had a median cost of approximately $1,329, CPT code 43242

had a median cost of approximately $1,074, CPT code 43510 had a median cost of approximately $1,471, and CPT code 43870 had a median cost of approximately $1,509. Based on the proposed rule median costs, we proposed to reassign the four CPT codes to APC 0422, which had a proposed APC median cost of approximately $1,136.

Our review of the CY 2011 final rule claims data indicates that the median costs for these CPT codes continue to be more consistent with assignment to APC 0422. Specifically, CY 2011 final rule claims data shows that CPT code 43216 has a final rule median cost of approximately $1,100, CPT code 43242 has a final rule median cost of approximately $1,067, CPT code 43510 has a final rule median cost of approximately $1,362, and CPT code 43870 has a final rule median cost of approximately $1,454. Based on our examination of the CY 2011 OPPS final rule claims data, we continue to believe that CPT codes 43216, 43242, 43510, and 43870 are appropriately placed in APC 0422, which has a final rule APC median cost of approximately $1,137, based on clinical homogeneity and resource costs.

Comment: Some commenters specifically disagreed with the APC reassignment of CPT code 43242, which describes an ultrasound procedure, because, the commenters stated, all the other ultrasound procedures would continue to be assigned to APC 0141. The commenters believed that the change may result in upcoding that could lead to incorrect coding or inappropriate payment, and suggested that, to help eliminate upcoding, CMS create a new APC specifically for ultrasound upper GI procedures. Specifically, the commenters suggested the creation of a new APC whose payment rate would be between the Level I Upper GI Procedures APC 0141 and Level II Upper GI Procedures APC 0422. The commenters stated that the restructuring of the current two APCs to three upper level GI APCs would provide appropriate payment for upper GI procedures consistent with CMS' policy of APC restructuring based on resource homogeneity, clinical homogeneity, provider concentration, frequency of service, and minimal opportunities for upcoding and code fragmentation.

Response: Based on our review of the hospital outpatient claims data used for ratesetting for the proposed rule, we determined that a change in APC assignment for CPT code 43242 was necessary. As we describe above, we continue to believe that the service associated with CPT code 43242 is more similar in resource use to those services assigned to APC 0422.

We do not agree with the commenters' suggestion for creating a new APC specific to ultrasound upper GI procedures. Based on our medical review team's assessment of the clinical characteristics of the procedure described by CPT code 43242 and the other procedures assigned to APC 0422, and based on the proposed rule and final rule claims data, we believe that CPT code 43242 is similar clinically and in terms of resource utilization to the upper GI procedures in APC 0422. Therefore, for CY 2011, as we proposed, we will reassign CPT code 43242 to APC 0422. We note that, in all cases, hospitals must report HCPCS codes that accurately reflect the services furnished; upcoding in order to receive higher payment is considered fraudulent billing.

Comment: Several commenters requested that CMS reassign CPT code 43240 from APC 0141 to APC 0384 (GI Procedures with Stents), which had a proposed payment rate of approximately $1,876. The commenters believed that CPT code 43240 would be appropriately placed in APC 0384 based on resource and clinical homogeneity to other procedures assigned to APC 0384.

Response: After review of our claims data for both the proposed rule and the final rule and consideration of the clinical characteristics, we do not agree with the commenters' recommendation to reassign CPT code 43240 to APC 0384. We believe that the procedure described by CPT code 43240 shares clinical similarities with the other upper GI procedures assigned to APC 0141. Furthermore, our CY 2011 final rule claims data show that the median cost for CPT code 43240 of approximately $738 based on 30 single claims (out of a total of 116 total claims) is substantially dissimilar to the median cost of approximately $1,893 for APC 0384. We believe that the final rule median cost of approximately $738 is more similar to the median cost of approximately $605 for APC 0141. Therefore, for CY 2011, we will continue to assign CPT code 43240 to APC 0141.

Comment: One commenter stated that the proposed payment reduction for APC 0422 from $1,635 for CY 2010 to $1,113.48 for CY 2011 will restrict Medicare beneficiary access to services that are in APC 0422. The commenter further stated that the payment rate for APC 0422 is inadequate to pay for the medical device required to perform the service described by CPT code 43228.

Response: Review of our CY 2011 final rule claims data shows that the median cost for CPT code 43228 is approximately $1,797 based on 1,759 single claims (out of a total of 2,199 claims), which is relatively similar to the final rule median cost of $1,137 for APC 0422, which includes many upper GI procedures such as the procedure described by CPT code 43228. Therefore, we continue to believe that the procedure described by CPT code 43228 is appropriately placed in APC 0422 based on resource and clinical homogeneity to other procedures currently assigned to APC 0422. We note that our cost-finding methodology is based on reducing each hospital's charge for its services to an estimated cost by applying the most discrete hospital-specific CCR available for the hospital that submitted the claim. Hence, it is the hospital's claims and cost reports that determine the estimated costs that are used to calculate the median cost for each service and, when aggregated into APC groups, the hospital data is used to calculate the median cost for the APC on which the APC payment rate is based.

With regard to the commenter's statement that hospitals will reduce access to these services for Medicare beneficiaries if the payment for them declines, we note that our regulations at 42 CFR 489.53(a)(2) permit CMS to terminate a hospital's provider agreement if the hospital places restriction on the persons it will accept for treatment and fails either to exempt Medicare beneficiaries from those restrictions or to apply them to Medicare beneficiaries the same as to all other persons seeking care.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to reassign CPT codes 43216, 43242, 43510, and 43870 from APC 0141 to APC 0422, which has a final CY 2011 APC median cost of approximately $1,137. We also are finalizing our CY 2011 proposal, without modification, to continue to assign CPT code 43240 to APC 0141, which has a final CY 2011 APC median cost of approximately $605, and to continue to assign CPT code 43228 to APC 0422, which has a final CY 2011 APC median cost of approximately $1,137.

3. Genitourinary Services

a. Radiofrequency Remodeling of Bladder Neck (APC 0165)

For CY 2011, we proposed to continue to assign Category III CPT code 0193T

(Transurethral, radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence) to APC 0165 (Level IV Urinary and Anal Procedures), with a proposed payment rate of approximately $1,403. This CPT code has been assigned to APC 0165 since it became effective in CY 2009.

Comment: Some commenters disagreed with the proposed continued APC assignment of CPT code 0193T to APC 0165. The commenters believed that the proposed payment rate for APC 0165 does not accurately reflect the costs incurred by hospitals that perform the procedure described by CPT code 0193T, especially because the procedure itself utilizes a costly single-use disposable medical device. The commenters suggested the assignment of CPT code 0193 to APC 0202 (Level VII Female Reproductive Procedures), which had a proposed payment rate of $3,086, because APC 0202 contains procedures that are very similar to the provedure described by CPT code 0193T. Specifically, the commenters indicated that CPT code 0193T is similar in clinical characteristics and resource costs to HCPCS codes 58356 (Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed) and 58565 (Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants), which are assigned to APC 0202. As an alternative, the commenters recommended the reassignment of CPT code 0193T to APC 0168 (Level II Urethral Procedures), which had a proposed payment rate of $2,211, because CPT code 0193T is also similar clinically and resource costs to CPT code 51715 (Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck), which are assigned to APC 0168. The commenters added that the probe used in the procedure associated with CPT code 0193T costs $1,095, and, overall, the total procedure cost with the probe is approximately $2,600.

Response: We do not have any CY 2009 hospital claims data for CPT code 0193T, which became effective on January 1, 2009. Category III CPT codes are temporary codes that describe emerging technology, procedures, and services, and these CPT codes were created by AMA to allow for data collection for new services or procedures. Under the OPPS, we generally assign new Category III CPT codes to clinical APCs based on input from a variety of sources, including, but not limited to, review of resource costs and clinical homogeneity of the service to existing procedures, information from specialty societies, input from our medical officers, and other information available to us. Based on our review of the clinical characteristics of CPT code 0193T, as well as the other procedures assigned to APCs 0165, 0168, and 0202, we continue to believe that the most appropriate APC for CPT code 0193T is APC 0165, and that the procedures contained in APC 0165 are clinically similar to that of CPT code 0193T. As we have stated in the past (74 FR 60446), we do not agree with the commenters that the procedures assigned to APC 0202 that involve fallopian tube cannulation or endometrial ablation are sufficiently similar to the procedure described by CPT code 0193T based on procedure duration, device utilization, use of guidance, or other characteristics to warrant reassignment of CPT code 0193T to APC 0202 based on considerations of clinical homogeneity. We also do not believe that CPT code 0193T is sufficiently similar to CPT code 51715, which involves an endoscopic injection of implant material, to warrant reassignment.

Furthermore, we note that, at the August 2009 APC Panel meeting, a presenter requested that the APC Panel recommend that CMS reassign CPT code 0193T to either APC 0202 or APC 0168 based on resource intensiveness and therapeutic benefit. The presenter claimed that the device cost associated with CPT code 0193T is comparable to those single-use devices that are used with certain procedures listed under APC 0202, specifically those described by CPT codes 58356, 58565, and 57288. This same presenter indicated that, unlike the medical devices used in the procedures that are in APC 0202, the costs of the single-use medical devices for the procedures in APC 0165 are very minimal. After a discussion, the APC Panel recommended that CMS maintain the APC assignment of CPT code 0193T to APC 0165.

After consideration of the public comments we received, we are finalizing our proposal, without modification, to continue to assign CPT code 0193T to APC 0165, which has a final CY 2011 median cost of approximately $1,369.

For CY 2011, the AMA CPT Editorial Panel decided to delete Category III CPT code 0193T on December 31, 2010, and replace it with CPT code 53860 (Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence) effective January 1, 2011. Similar to its predecessor CPT code, the replacement CPT code 53860 will be assigned to APC 0165 effective January 1, 2011.

b. Percutaneous Renal Cryoablation (APC 0423)

For CY 2011, we proposed to continue to assign CPT code 50593 (Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy) to APC 0423 (Level II Percutaneous Abdominal and Biliary Procedures), with a proposed payment rate of approximately $3,905. This CPT code was a new code in CY 2008; however, the same service was previously described by CPT code 0135T (Ablation renal tumor(s), unilateral, percutaneous, cryotherapy). We note that, for CY 2007, based upon the APC Panel's recommendation made at its March 2006 meeting, we reassigned CPT code 50593 (then CPT code 0135T) from APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures) to APC 0423, effective January 1, 2007.

Comment: One commenter expressed concern that the proposed payment rate of approximately $3,905 for CPT code 50593 is inadequate because the payment does not accurately account for the costs incurred by hospitals in performing the procedure described by this code. The commenter argued that the proposed payment rate for CPT code 50593, which the commenter considered low, is attributable to claims data that do not accurately capture the full costs of CPT code 50593 because only 57 percent of the claims data used to establish the median cost for this procedure were correctly coded, and that the single claims do not contain the HCPCS code and associated charge for the required device, specifically HCPCS code C2618 (Probe, cryoablation). The commenter requested that CMS designate CPT code 50593 as a device-dependent procedure, which would require hospitals to submit claims with the appropriate device HCPCS code, assign the procedure to its own APC, and set the payment rate for that APC based on claims for CPT code 50593 reported with HCPCS code C2618. The commenter argued that this request would be appropriate because the procedure described by CPT code 50593 cannot be performed without the utilization of the device described by HCPCS code C2618. The commenter's analysis concluded that the median cost on which payment for CPT code 50593 would be based if the request were honored would be approximately $5,598, resulting in a more accurate payment rate for the procedure and continued Medicare beneficiary access to percutaneous renal cryoablation in the hospital outpatient setting. The

commenter further stated that, although APC 0423 groups similar ablation procedures, none of the other procedures in the APC involve high-cost devices.

Response: We continue to believe that CPT code 50593 is appropriately assigned to APC 0423 based on clinical and resource considerations when compared to other procedures also proposed for assignment to APC 0423 for CY 2011. As we stated in the CY 2007 OPPS final rule with comment period (71 FR 68049 through 68050), the CY 2008 OPPS/ASC final rule with comment period (72 FR 66709), the CY 2009 OPPS/ASC final rule with comment period (73 FR 68611), and the CY 2010 OPPS/ASC final rule with comment period (74 FR 60444), we initially revised the APC assignment for the percutaneous renal cryoablation procedure from APC 0163 to APC 0423 in CY 2007 based on the APC Panel's recommendation to reassign the procedure to APC 0423. The median costs of the four HCPCS codes assigned to APC 0423 for CY 2011 range from approximately $3,477 to $4,736, well within the two-fold variation in median cost that is permitted by law for an OPPS payment group. Even if we were to calculate the median cost for CPT code 50593 using only claims that also contain HCPCS code C2618, estimated by the commenter to be approximately $5,598 using proposed rule data, the grouping of these procedures in the same APC would not violate the 2 times rule.

We also do not agree that CPT code 50593 should be designated as a device-dependent procedure and assigned to its own separate APC. We have only 344 single claims (out of a total of 757 claims) for CPT code 50593 from CY 2009 and, as such, the procedure has the second lowest frequency of the four procedures assigned to APC 0423. As we stated in the CY 2010 OPS/ASC final rule with comment period (74 FR 60444 through 60445), we continue to believe this relatively low volume procedure should be assigned to a payment group with similar services, as we have proposed, in order to promote payment stability and encourage hospital efficiency. In addition, we do not identify individual HCPCS codes as device-dependent HCPCS codes under the OPPS. Rather, we first consider the clinical and resource characteristics of a procedure and determine the most appropriate APC assignment. When we determine that we should assign a procedure to an APC that is device-dependent, based on whether that APC has been historically identified under the OPPS as having very high device costs, we then consider the implementation of device edits, as appropriate. We again note that the identification of device-dependent APCs was particularly important in the early years of the OPPS when separate pass-through payment for many implantable devices expired. At that time, a variety of methodologies to package the costs of those devices into procedural APCs was utilized over several years to ensure appropriate incorporation of the device costs into the procedure payments. At this point in time, hospitals have significantly more experience reporting HCPCS codes for packaged and separately payable items and services under the OPPS and the payment groups are more mature. We believe our standard ratesetting methodology typically results in appropriate payment rates for new procedures that utilize devices, as well as those that do not use high cost devices. In recent years, we have not encountered circumstances for which we have had to establish new device-dependent APCs because we were not able to accommodate the clinical and resource characteristics of a procedure by assigning it to an existing APC (whether device-dependent or non-device-dependent), and the procedure described by CPT code 50593 is not an exception.

While all of the procedures assigned to APC 0423 require the use of implantable devices, for many of the procedures, there are no Level II HCPCS codes that describe all of the technologies that may be used in the procedures. Therefore, as we indicated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60445), it would not be possible for us to develop procedure-to-device edits for all of the CPT codes assigned to APC 0423. Under the OPPS, there are many other procedures that require the use of implantable devices that, because they are assigned to OPPS APCs that are not device-dependent, do not have procedure-to-device edits applied, even if those claims processing edits would be feasible. We continue to believe that our payments for procedures that utilize high cost devices are appropriate for those services, even when those services are grouped with other procedures that either do not require the use of implantable devices or which utilize devices that are not described by specific Level II HCPCS codes.

When reporting CPT code 50593, we expect hospitals to also report the device HCPCS code C2618, which is associated with this procedure. We also remind hospitals that they must report all of the HCPCS codes that appropriately describe the items used to provide services, regardless of whether the HCPCS codes are packaged or paid separately. If hospitals use more than one probe in performing the procedure described by CPT code 50593, we expect hospitals to report this information on the claim and adjust their charges accordingly. Hospitals should report the number of cryoablation probes used to perform the procedure described by CPT code 50593 as the units of HCPCS code C2618 which describes these devices, with their charges for the probes. Since CY 2005, we have required hospitals to report device HCPCS codes for all devices used in procedures if there are appropriate HCPCS codes available. In this way, we can be confident that hospitals have included charges on their claims for costly devices used in procedures when they submit claims for those procedures.

After consideration of the public comment we received, we are finalizing our CY 2011 proposal, without modification, to continue to assign CPT code 50593 to APC 0423, which has a final CY 2011 APC median cost of approximately $3,855.

4. Nervous System Services

a. Pain-Related Procedures (APCs 0203, 0204, 0206, 0207, and 0388)

For CY 2011, we proposed to set the payment rates for APCs to which pain-related procedures were assigned based on the median costs determined under the standard OPPS ratesetting methodology. Specifically, we proposed the following CY 2011 payment rates for the pain-related APCs: APC 0203 (Level IV Nerve Injections), with a proposed payment rate of approximately $908; APC 0204 (Level I Nerve Injections), with a proposed payment rate of approximately $182; APC 0206 (Level II Nerve Injections), with a (proposed payment rate of approximately $265); APC 0207 (Level III Nerve Injections), with a proposed payment rate of approximately $527), and APC 0388 (Discography), with a proposed payment rate of approximately $1,702).

For CY 2011, we proposed to reassign CPT codes 62273 (Injection, epidural, of blood or clot patch) and 64408 (Injection, anesthetic agent; vagus nerve) from APC 0206 to APC 0207, and to reassign CPT code 62319 (Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural

or subarachnoid; lumbar, sacral (caudal)) from APC 0207 to APC 0203. Table 24 provides the CPT codes on which we received comments together with the CY 2010 APC assignment, the CY 2011 proposed rule APC assignment, and the CY 2011 final rule APC assignment for each code.

TABLE 24—PAIN-RELATED PROCEDURES ON WHICH WE RECEIVED PUBLIC COMMENTS

CPT Code	Long descriptor	CY 2010 APC	Proposed CY 2011 APC	Final CY 2011 APC
62273	Injection, epidural, of blood or clot patch), 64408 (Injection, anesthetic agent; vagus nerve.	0206	0207	0207
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic.	0207	0207	0207
62319	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal).	0207	0203	0203
64408	Injection, anesthetic agent; vagus nerve	0207	0207	0207
64410	Injection, anesthetic agent; phrenic nerve	0207	0207	0207
64412	Injection, anesthetic agent; spinal accessory nerve	0207	0207	0207
64480	Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, each additional level (List separately in addition to code for primary procedure).	0206	0206	0206
64484	Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure).	0206	0206	0206
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure).	0204	0204	0204
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure).	0204	0204	0204
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level.	0207	0207	0207
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure).	0204	0204	0204
64623	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure).	0207	0207	0207
64626	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level.	0207	0207	0207
64627	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure).	0204	0204	0204
72285	Discography, cervical or thoracic, radiological supervision and interpretation	0338	0338	0338
72295	Discography, lumbar, radiological supervision and interpretation	0338	0338	0338

Comment: One commenter objected to what the commenter stated were continuing declines in OPPS payment for CPT add-on codes 64491, 64492, 64493, 64494, 64480, 64484, 64623, and 64627. The commenter objected both to the declines in the payment rates, which they indicate have been as much as 50 percent since CY 2007, and to the application of the multiple procedure reduction to them which further reduces the payment for them by both Medicare and other payers.

Response: CPT codes 64491, 64492, 64493, and 64494 were new codes in CY 2010. Therefore, we do not have CY 2009 claims data on which to calculate a median cost for CY 2011 ratesetting purposes. In accordance with our standard ratesetting policy, we proposed to assign the new codes to the APCs that our clinicians believe are appropriate based on their understanding of the nature of the service and the resources that are required by services that they believe to be comparable. These codes had new interim APC placements for CY 2010 and were open to a 60-day public comment period. We received no public comments objecting to the APC placement of the new codes.

With regard to the variation in costs for CPT codes 64480, 64484, 64623, and 64627, as we have stated in the past, OPPS payment rates fluctuate based on a variety of factors, including, but not limited to, changes in the mix of hospitals billing the services, differential changes in hospital charges and costs for the services, and changes in the volumes of services reported (74 FR 60447). Therefore, the median costs upon which the OPPS payment rates are based vary from one year to another. We note that the median costs of all of the APCs to which CPT codes 64480, 64484, 64623, and 64627 are assigned increased

between CY 2009 and CY 2010 and again between CY 2010 and CY 2011. Specifically, for CPT codes 64480 and 64484, the median cost of APC 0206 to which they are assigned increased from approximately $236 in CY 2009 to approximately $249 in CY 2010 and to approximately $265 based on CY 2011 final rule data. In the case of CPT code 64627, the median cost of APC 0204 to which CPT code 64627 is assigned increased from approximately $161 in CY 2009 to approximately $171 in CY 2010 and to approximately $182 based on CY 2011 final rule data. Lastly, for CPT code 64623, the median cost of APC 0207 to which the code is assigned increased from approximately $463 in CY 2009 to approximately $481 in CY 2010 and to approximately $517 based on final rule data for CY 2011. We are finalizing the APC assignments for all of these procedures as shown in Table 24.

With regard to the application of the multiple procedure reduction for APCs 0204, 0206, and 0207, we continue to believe that it is appropriate to reduce the payment for services furnished in these APCs by 50 percent when they are furnished with a procedure that is paid at the same or a higher rate because we believe that there are significant efficiencies associated with providing multiple procedures during the same encounter.

Comment: One commenter objected to the proposed payment rate for CPT codes 72285 and 72295, which the commenter indicated is a 73-percent increase compared to the CY 2007 OPPS payment rate. The commenter stated that CPT codes 62290 (Injection procedure for discography, each level; lumbar) and 62291 (Injection procedure for discography, each level; cervical or thoracic) describe the procedures and that CPT codes 72285 and 72295 are paid at an unreasonable rate.

Response: As we have noted in the past (74 FR 60447), CPT codes 72285 and 72295, both of which are assigned to APC 0388, are "T" packaged codes and, as such, are paid separately only if there is no separately paid surgical procedure with a status indicator of "T" on the same claim. When there is a separate payment made for these services, the payment is not only payment for the service itself but also includes payment for all services reported on the claim that are always packaged (that is, those with a status indicator of "N"). The median cost of APC 0388 to which CPT codes 72285 and 72295 are assigned for payment when separate payment can be made increased from approximately $1,470 in CY 2009 to approximately $1,727 in CY 2010 and decreased to approximately $1,654 based on final rule data for CY 2011. The median costs reflect the cost of all conditionally and unconditionally packaged services on the claim. Payment for CPT codes 62290 and 62291 is always packaged into payment for the independent, separately paid procedures with which these codes are reported because we believe that these codes are ancillary and supportive to other major separately paid procedures and that they are furnished only as an ancillary and dependent part of an independent separately paid procedure. Therefore when CPT codes 72285 and 72295 are the only separately paid procedures that appear on the claim, payment for CPT codes 72285 and 72295 includes the payment for CPT codes 62290 and 62291.

Comment: One commenter supported the proposed payment for CPT code 62273 and 62318.

Response: We appreciate the commenter's support.

Comment: One commenter argued that the proposed payment rates for CPT codes 64408, 64410, and 64412 are excessive because these codes were proposed to be paid at the same level as epidural and neurolytic injections. The commenter objected to neurolytic epidural injections receiving less payment than the payment proposed for these services. The commenter did not identify the CPT codes of concern.

Response: We proposed to assign CPT codes 64408, 64410, and 64412 to APC 0207 based on what our clinicians believe to be clinical similarity with other procedures in APC 0207 and because these procedures have median costs that are similar to the median costs of other procedures in APC 0207. We continue to believe that these APC assignments are correct and are finalizing the proposed assignments. We are unable to compare the clinical characteristics of the services without knowing the specific CPT codes of the epidural and neurolytic injections of concern to the commenter.

Comment: One commenter objected to the proposed reassignment of CPT code 62319 from APC 0207 to APC 0203. The commenter believed this proposed reassignment would result in excessive payment for CPT code 62319.

Response: CPT code 62319 is assigned to APC 0207 for CY 2010, with a national unadjusted payment rate of approximately $485. We proposed to reassign CPT code 62319 from APC 0207 to APC 0203 because the proposed rule median cost for CPT code 62319 was approximately $887 and, therefore, was far more similar to the proposed rule median cost of approximately $926 for APC 0203 than it was similar to the proposed rule median cost of approximately $537 for APC 0207. In the final rule claims data, the median cost for CPT code 62319, which is approximately $801, continues to be more similar to the median cost of approximately $872 for APC 0203 than to the median cost of approximately $517 for APC 0207. Therefore, we are assigning CPT code 62319 to APC 0203 for CY 2011 as we proposed.

Comment: One commenter objected to the proposed reduction in payment for CPT code 64626 from $908.40 for CY 2010 to $527.12 for CY 2011. The commenter believed that the proposed reduction results from a reassignment of the code to a new category.

Response: CPT code 64626 is assigned to APC 0207 for CY 2010 and the national unadjusted payment rate is approximately $485. For CY 2011, we did not propose to reassign CPT code 64626 as the commenter believed. For CY 2011, we proposed to continue to assign CPT code 64626 to APC 0207, for which we proposed a national unadjusted payment rate of approximately $527. Based on our analysis of final rule claims data, we are continuing to assign CPT code 64626, which has a final rule median cost of approximately $915, to APC 0207, which has a final rule median cost of approximately $517. We continue to believe that CPT code 64626 is clinically similar and requires resources similar to the other codes that are assigned to APC 0207. We note that there are no 2 times violations in APC 0207.

After consideration of the public comments we received, we are finalizing our CY 2011 proposals, without modification, to pay for CPT codes 64491, 64492, 64493, 64494, 64480, 64484, 64623, 64627, 72285, 72295, 64408, 64410, 64412, 62318, 62319, and 64626 through APCs 0203, 0204, 0206, 0207, and 0388, as shown in Table 24 above. APC 0203 has a CY 2011 final rule median cost of approximately $872, APC 0204 has a CY 2011 final rule median cost of approximately $182, APC 0206 has a CY 2011 final rule median cost of approximately $265, APC 0207 has a CY 2011 final rule median cost of approximately $517, and APC 0388 has a CY 2011 final rule median cost of approximately $1,654. We are finalizing our proposed assignment of CPT code 62273 to APC 0207. We also are finalizing our proposed reassignment of CPT code 62319 from APC 0207 to APC 0203, and we are continuing to assign CPT code 64626 to APC 0207.

b. Revision/Removal of Neurostimulator Electrodes (APC 0687)

For CY 2011, we proposed to continue to assign CPT codes 63661 (Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed), 63662 (Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed), 63663 (Revision, including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed), and 63664 (Revision, including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed) to APC 0687 (Revision/Removal of Neurostimulator Electrodes), for which we proposed a CY 2011 median cost of approximately $1,527. For CY 2010, these CPT codes were assigned to APC 0687, which has a CY 2010 national unadjusted payment rate of approximately $1,324. These new codes were created effective for services performed on or after January 1, 2010, when the AMA CPT Editorial Board deleted CPT code 63660 (Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)) and created new CPT codes 63661, 63662, 63663, and 63664 to differentiate between revision and removal procedures, and to also differentiate between percutaneous leads (arrays) and surgical leads (plates/paddles). In accordance with our standard policy, we indicated in Addendum B of the CY 2010 final rule that the APC assignments for these new CPT codes for CY 2010 were new interim APC assignments by showing comment indicator "NI" for each new code, and we accepted public comment on them. We received public comments both in response to the CY 2010 final rule interim APC assignment and in response to our CY 2011 proposal to continue to assign the new codes to APC 0687. We have incorporated the CY 2010 final rule comments and responses into the summary of the comments and responses on our proposal to continue to assign the new codes to APC 0687 for CY 2011.

Comment: Commenters supported the placement of CPT codes 63661 and 63662 in APC 0687. However, they objected to the placement of CPT codes 63664 and 63665 in APC 0687 because, they stated, these codes are used to report both revision and replacement of neurostimulator electrodes. The commenters believed that hospital resources are substantially greater when neurostimulator electrodes are being replaced rather than revised. They asked that CMS create and require hospitals to use four new Level II alpha numeric codes to report these services in place of the CPT codes. Specifically, they asked that CMS create Level II alpha numeric HCPCS codes for (1) Revision of spinal neurostimulator electrode percutaneous arrays; (2) Revision of spinal neurostimualtor electrode plate/paddle arrays; (3) Replacement of spinal neurostimulator electrode percutaneous arrays; and (4) Replacement of spinal neurostimulator electrode plate/paddle arrays. They stated that CMS could continue to assign the two new HCPCS codes for revision of electrodes to APC 0687, which has a CY 2010 national unadjusted payment rate of approximately $1,324. However, the commenters suggested stated that CMS assign the new HCPCS codes for replacement of percutaneous electrodes to device-dependent APC 0040 (Percutaneous Implantation of Neurostimulator Electrodes), which has a CY 2010 national unadjusted payment rate of approximately $4,429. They also suggested that CMS assign the new HCPCS codes for replacement of plate/paddle electrodes to device dependent APC 0061 (Laminectomy, Laproscopy, or Incision for Implantation of Neurostimulator Electrodes), which has a CY 2010 national unadjusted payment rate of approximately $5,832. The commenters believed that the creation of the two Level II alpha numeric HCPCS codes for replacement of the neurostimulator electrode devices and their assignment to device-dependent APCs 0040 and 0061 are necessary to ensure that hospitals are paid appropriately for the cost of the electrodes that are inserted during a replacement procedure. One commenter stated that an analysis of the registration information it maintains on individual patients, products, and associated procedures from June 2004 to April 2010 shows that 343 lead revisions would currently fall into CPT code 63663 or 63664. The commenter further stated that, of these 343 cases, 22 percent were revised without a device while 78 percent were revised with replacement of a device (the commenter provided aggregate information across both CPT codes). The commenter indicated that its data support the need to create the new Level II alpha numeric HCPCS codes and to assign the codes for neurostimulator electrode replacement to APCs 0040 and 0061. The commenter stated that CMS has created Level II alpha numeric HCPCS codes for the same reason in the past and, therefore, has a precedent for creating the Level II alpha numeric HCPCS codes as the commenter requested.

Response: For CY 2011, we are assigning CPT codes 63661, 63662, 63663, and 63664 to APC 0687 as we proposed, with a CY 2011 final rule median cost of approximately $1,480. We do not have CY 2009 claims data on the cost of these codes upon which to make an assessment of whether there is a meaningful difference between the cost of revising the electrodes or replacing them. Therefore, we are not convinced by the commenters that the use of the CPT codes for these services and the assignment of the codes for revision/replacement of neurostimulator electrodes to APC 0687 are inappropriate. Further, the OPPS is a payment system of averages in which the payment for a service is based on the estimated relative cost of the service, including a range of supply and other input costs, as well as other services in the same APC that are comparable in resource cost and clinical homogeneity. We expect that hospital charges for a service, which are derived from the cost of a service, can vary across individual patients. Therefore, we expect variability in the estimated cost of a service, across cases in a hospital and among hospitals, to be reflected at some level in the final APC relative payment weight. Further, hospitals frequently advise us that when we create and require that they report Level II alpha numeric HCPCS codes to report services for which CPT codes exist, it imposes a significant and costly administrative burden on them. Hence, we prefer not to create Level II alpha numeric codes unless there is a strong need to do so to administer the Medicare program, particularly when there are CPT codes that can be used to accurately report the service. However, we will examine estimated costs for these four new CPT codes in the CY 2010 claims data we will use to model the CY 2012 proposed rule when that data are available.

After carefully considering the public comments we received in response to the CY 2010 final rule with comment period and the CY 2011 proposed rule, we are continuing to assign CPT codes 63661, 63662, 63663, and 63664 to APC 0687, with a CY 2011 final rule median cost of approximately $1,480.

5. Radiation Therapy Services

a. Stereotactic Radiosurgery (SRS) Treatment Delivery Services (APCs 0065, 0066, 0067, and 0127)

For CY 2011, we proposed to continue to assign CPT code 77371 (Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based) to APC 0127 (Level IV Stereotactic Radiosurgery, MRgFUS, and MEG), with a proposed payment rate of approximately $7,221.

We also proposed to continue to recognize four existing HCPCS G-codes that describe linear accelerator-based SRS treatment delivery services for separate payment in CY 2011. Specifically, we proposed the following: to assign HCPCS code G0173 (Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session) and HCPCS code G0339 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment) to APC 0067 (Level III Stereotactic Radiosurgery, MRgFUS, and MEG), with a proposed payment rate of approximately $3,414; to assign HCPCS code G0251 (Linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment) to APC 0065 (Level I Stereotactic Radiosurgery, MRgFUS, and MEG), with a proposed payment rate of approximately $960; and to assign HCPCS code G0340 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment) to APC 0066 (Level II Stereotactic Radiosurgery, MRgFUS, and MEG), with a proposed payment rate of approximately $2,517.

Further, we proposed to continue to assign SRS CPT codes 77372 (Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of 1 session); linear accelerator based) and 77373 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions) status indicator "B" (Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x)) under the OPPS, to indicate that these CPT codes are not payable under the OPPS.

Comment: One commenter urged CMS to reevaluate the APC assignments for the linear accelerator-based (LINAC) and robotic Cobalt-60 based stereotactic radiosurgery (r-SRS) HCPCS codes, given the recent introduction of a frameless Cobalt-60 system that can be used to deliver treatments in multiple sessions. The commenter stated that no clinical data exist to support the need for differential payments for LINAC-based and Cobalt-60 r-SRS procedures. The commenter further explained that current medical literature cites no difference in clinical effectiveness for one system over another, and stated that treatment with a Cobalt-60 system, when compared to LINAC-based system, does not lead to superior outcomes. The commenter recommended that CMS assign HCPCS code G0339 and CPT code 77371 to the same APC, thereby establishing payment parity for the complete course of treatment for intracranial and other head and neck r-SRS, regardless of equipment, energy source, or whether a frame is used in the procedure. In addition, the commenter argued that this APC reevaluation is necessary to protect the Medicare program and beneficiaries from excessive costs associated with Cobalt-60 system, when both the LINAC-based and Cobalt-60 systems are similar in clinical homogeneity and resource costs.

Response: We disagree with the comment's argument that the LINAC-based and Cobalt-60 based systems have similar resource costs. For the past several years, we have seen resource differences based on the median costs for the LINAC-based and Cobalt-60 based systems, and analysis of our claims data show that the median costs for LINAC-based and Cobalt-60 SRS procedures vary significantly. Since CY 2007, when CPT code 77371 became effective, our claims data have shown consistently a median cost of more than $7,000 for the service associated with the Cobalt-60 system, which is higher than the median cost of approximately $3,500 for the LINAC-based system (described by HCPCS G-code G0339).

Analysis of the updated CY 2009 claims data used for this final rule with comment period indicates that the code-specific median costs for the LINAC-based and Cobalt-60 systems continue to vary. Our updated claims data on the hospital outpatient claims available for CY 2011 ratesetting show a median cost of approximately $7,580 for CPT code 77371 based on 529 single claims (out of a total of 4,336 claims), which is significantly higher than the median costs associated with HCPCS codes G0173, G0251, G0339, and G0340. Specifically, our claims data indicate a median cost of approximately $2,960 for HCPCS code G0173 based on 627 single claims (out of a total of 1,460 claims), a median cost of approximately $964 for HCPCS code G0251 based on 7,005 single claims (out of a total of 7,739 claims), a median cost of approximately $3,510 for HCPCS code G0339 based on 5,762 single claims (out of a total of 7,735 claims), and a median cost of approximately $2,478 for HCPCS code G0340 based on 18,539 single claims (out of a total of 18,713 claims). Because the median costs of HCPCS code G0339 and CPT code 77371 vary significantly, we do not believe it would be appropriate to provide OPPS payment through a single APC for these r-SRS treatment delivery services in CY 2011. We continue to believe that APC 0127 is an appropriate APC assignment for CPT code 77371, and, similarly, that APC 0067 is an appropriate APC assignment for HCPCS code G0339 based on consideration of the clinical characteristics associated with these procedures and based on the median costs for these services calculated from the most recently available hospital outpatient claims and cost report data. Consistent with our current policy to annually assess the appropriateness of the APC assignments for all services under the hospital OPPS, we will continue to monitor our claims data for the SRS treatment delivery services in the future.

As we have stated in the past (74 FR 60456), the OPPS is a prospective payment system, where APC payment rates are based on the relative costs of services as reported to us by hospitals according to the most recent claims and cost report data as described in section II.A. of this final rule with comment period. The 2 times rule specifies that the median cost of the highest cost item or service within a payment group may be no more than 2 times greater than the median cost of the lowest cost item or service within the same group. Based on the 2 times rule, HCPCS code G0339 and CPT code 77371 could not be assigned to the same APC and, because hospitals continue to report very different costs for these services, we believe it is appropriate to maintain their assignments to different payment groups for CY 2011. As a matter of payment policy, the OPPS does not set payment rates for services based on considerations of clinical effectiveness. Furthermore, in accordance with the statute, we budget neutralize the OPPS each year in the annual update so that projected changes in spending for

certain services are redistributed to payment for other services.

After consideration of the public comments we received, we are finalizing our CY 2011 proposals, without modification, to continue to assign CPT code 77371 to APC 0127, which has a final CY 2011 APC median cost of approximately $7,580, and to continue to assign HCPCS code G0339 to APC 0067, which has a final CY 2011 APC median cost of approximately $3,372.

Comment: One commenter recommended that CMS redefine HCPCS G-code G0340 to include subsequent fractions delivered with both robotic LINAC-based and Cobalt-60 based systems because r-SRS can now be performed with the Cobalt-60 system based over 2 to 5 fractions.

Response: Earlier this year, we met with stakeholders to discuss this topic, particularly with respect to the OPPS payment assignment of the LINAC-based and Cobalt-60 SRS procedures. At this meeting we were informed of recent technological developments that existed in Europe that utilizes the Cobalt-60 systems to deliver treatments over multiple fractions. We were informed that, while the technology currently exists in Europe, it would eventually migrate to the United States. Because only one CPT code exists currently that describes a procedure that utilizes a Cobalt-60 system, we believe that stakeholders would seek guidance from the AMA CPT Editorial Panel on the appropriate reporting of this service if it is being provided in the United States in a manner that makes the current CPT coding insufficient or inappropriate. Specifically, CPT code 77371 is defined as "Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based," and does not describe a Cobalt-60 based multi-fraction service.

We believe that HCPCS G-code G0340 appropriately describes the service associated with a LINAC-based system that is delivered in multiple fractions. We do not agree that there is a programmatic need to modify the descriptor for HCPCS G-code G0340 due to potential changes in the Cobalt-60 system. We remind hospitals that HCPCS code G0340 describes a multi-fraction treatment delivery that utilizes a LINAC-based SRS technology.

Comment: One commenter requested that CMS finalize the proposed APC and status indicator assignments for HCPCS codes G0173, G0251, G0339, and G0340 for CY 2011 and the proposed assignment of status indicator "B" to CPT codes 77372 and 77373. The commenter also recommended that CMS revise the code descriptors for HCPCS code G0173, G0251, G0339, and G0340 to distinguish between robotic and non-robotic gantry-based SRS systems. Based on analysis of claims data for HCPCS codes G0339 and G0340, the commenter found that 33 percent of the claims submitted during CY 2009 were paid to hospitals without image-guided robotic SRS systems. The commenter suggested specific code descriptor changes for the four HCPCS G-codes to ensure submission of correctly coded claims. Alternatively, the commenter requested that CMS provide guidance on the reporting of the existing SRS HCPCS G-codes if no change is made to the HCPCS code descriptors.

Response: These HCPCS G-codes for SRS have been in effect for several years and, based on questions brought to our attention by hospitals, we have no reason to believe that hospitals are confused about the reporting of these codes. Moreover, based on our analysis of the hospital outpatient claims data that we use for ratesetting, we see resource differences reflected in the median costs of the four HCPCS G-codes that are reasonably consistent with our expectations for different median costs for the services based on the current code descriptors. We believe it would be confusing to hospitals if we were to revise the code descriptors for HCPCS codes G0173, G0251, G0339, and G0340 at this point in time and could lead to instability in our median costs and inaccurate payments for some services. Therefore, we believe that modifying the G-code descriptors is not necessary for us to continue to provide appropriate payment for the services they describe. Further, we have provided instruction on the reporting of these SRS codes in Chapter 4, Section 200.3 of the Medicare Claims Processing Manual of the Internet-Only Manual.

After consideration of the public comments we received, we are finalizing our CY 2011 proposals, without modification, to maintain the existing CY 2010 APC assignments for the SRS HCPCS codes for CY 2011. Specifically, we are continuing to assign HCPCS G-codes G0173 and G0339 to APC 0067, which has a final CY 2011 APC median cost of approximately $3,372; HCPCS G-code G0251 to APC 0065, which has a final CY 2011 APC median cost of approximately $967; HCPCS G-code G0340 to APC 0066, which has a final CY 2011 APC median cost of approximately $2,478; and CPT code 77371 to APC 0127, which has a final CY 2011 APC median cost of approximately $7,580. In addition, we are finalizing our proposals, without modification, to continue to assign CPT codes 77372 and 77373 to status indicator "B" under the OPPS.

b. Proton Beam Therapy (APCs 0664 and 0667)

For CY 2011, we proposed to continue to assign CPT codes 77520 (Proton treatment delivery; simple, without compensation) and 77522 (Proton treatment delivery; simple, with compensation) to APC 0664 (Level I Proton Beam Radiation Therapy), which had a proposed payment rate of approximately $902. We also proposed to continue to assign CPT codes 77523 (Proton treatment delivery; intermediate) and 77525 (Proton treatment delivery; complex) to APC 0667 (Level II Proton Beam Radiation Therapy), which had a proposed payment rate of approximately $1,180.

Comment: Several commenters supported the proposed payments for the proton beam treatment CPT codes. However, one commenter expressed concern over the proposed payment rates and requested an explanation on the fluctuation in payments for CPT codes 77520, 77522, 77523, and 77525 for the past 6 years, which the commenter displayed in a submitted table.

Another commenter expressed concern with the reduction in the relative weights for APCs 0664 and 0667. The commenter indicated that it understood that APC 0664 is exempt from the 2 times rule violation based on the list of APCs that appeared in Table 16 of the CY 2011 OPPS/ASC proposed rule, but stated that the decrease in the relative weights would result in decreased payments for these four CPT codes.

Response: In accordance with section 1833(t)(2)(B) of the Act and § 419.31 of the regulations, we annually review the items and services within an APC group to determine, with respect to comparability of the use of resources and clinical homogeneity. The payment rates, including the relative weights, set annually for these services are based on review of the claims data used for ratesetting. For the CY 2011 update, the payment rates for APCs 0664 and 0667 are based on data from claims submitted during CY 2009 according to the standard OPPS ratesetting methodology. Specifically, we used 11,963 single claims (out of 12,995 total claims) from CY 2011 proposed rule claims data (and we used 11,963 single claims (out of 12,995 total claims) from CY 2011 final rule claims data) to calculate the median cost upon which the CY 2011 payment rate for APC 0664 is based. In addition,

we used 2,799 single claims (out of 3,081 total claims) from CY 2011 proposed rule claims data (and we used 2,799 single claims (out of 3,081 total claims) from CY 2011 final rule claims data) to calculate the median cost for APC 0667.

For CY 2011, we are setting the final payment rate for proton beam therapy based on median costs of approximately $1,021 for APC 0664 and approximately $1,335 for APC 0667. These median costs result in modest declines in the final CY 2011 payment rates for proton beam therapy compared to the CY 2010 final payment rates. We note that our cost-finding methodology is based on reducing each hospital's charge for its services to an estimated cost by applying the most discrete hospital-specific CCR available for the hospital that submitted the claim. Hence, it is the hospital's claims and cost reports that determine the estimated costs that are used to calculate the median cost for each service and, when aggregated into APC groups, the hospital data are used to calculate the median cost for the APC on which the APC payment rate is based.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to pay for proton beam therapy through APCs 0664 and 0667, with payment rates based upon the most current claims and cost report data for these services. Specifically, we will continue to assign CPT codes 77520 and 77522 to APC 0664, with a final CY 2011 APC median cost of approximately $1,021, and CPT codes 77523 and 77525 to APC 0667, with a final CY 2011 APC median cost of approximately $1,335.

c. Device Construction for Intensity Modulated Radiation Therapy (APC 0303)

For CY 2011, we proposed to continue to assign CPT code 77338 (Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan) to APC 0303 (Treatment Device Construction), with a proposed payment rate of approximately $198. CPT code 77338 is a new code for CY 2010 and, therefore, there are no claims for it in the CY 2009 claims data on which we are basing the CY 2011 OPPS payment rates. In CY 2009, the services represented by CPT code 77338 were reported using CPT code 77334 (Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)). For CY 2010, CPT code 77338 is assigned to APC 0303, the same APC to which CMS assigned CPT code 77334. The CY 2010 OPPS payment rate for APC 0303 is approximately $191.

Comment: Commenters objected to the assignment of CPT code 77338 to APC 0303 for CY 2010 and to the proposal to continue to assign CPT code 77338 to APC 0303 for CY 2011. The commenters stated that CPT code 77338 is used to report all devices that are necessary for an intensive modulated radiation therapy (IMRT) treatment and that a typical treatment requires 3 to 9 devices, whereas CPT code 77334 is used to report a single device. Therefore, the commenters believed that the payment for one unit of 77338 should not be paid the same amount as one unit of CPT code 77334. The commenters stated that there are typically two courses of IMRT treatment furnished to patients; hence, before the creation of CPT code 77338, hospitals reported and were paid for 3 to 9 units of CPT code 77334 for each of the two treatments, resulting in an approximate total payment for all devices required for two courses of treatment ranging from roughly $1,500 to $3,500. The commenters stated that assignment of CPT code 77338 to the same APC as CPT code 77334 results in an inappropriate reduction in payment for the creation of the devices that are necessary to furnish IMRT. One commenter asked CMS to use the first 6 months of CY 2010 claims data, which would contain charges for CPT code 77338, to establish an appropriate payment rate for CPT code 77338.

Response: We examined our updated claims data to determine how many units of CPT code 77334 were reported in CY 2009 for each Medicare beneficiary who also received IMRT services. We found that the median number of units of CPT code 77334 that were furnished to patients who received IMRT in CY 2009 was eight. This finding is consistent with the commenters' statement that hospitals furnish three to nine devices per each of two IMRT treatments (a range of 6 to 18 devices across two treatments in a year). We then developed a simulated cost for one unit of CPT code 77338 by using the frequency information we acquired from the study and the median cost of one unit of CPT code 77334. We assumed that if a total of eight devices were typically furnished across two treatments, then approximately four devices were furnished for each treatment. We assumed that the cost of each device for IMRT would be approximately the same as a single unit of CPT code 77334 because one unit of CPT code 77334 represents one device. CPT code 77334 has a final rule median cost of approximately $198. Therefore, we estimated that the cost of the devices that would be reported by one unit of CPT code 77338 would be approximately $792 (4 devices at an estimated per device cost of $198 each). Using this hypothetical cost per unit for CPT code 77338, we determined that CPT code 77338 would most appropriately be assigned to APC 0310 (Level III Therapeutic Radiation Treatment Preparation), which has a final rule median cost of approximately $917. We chose not to use our estimated per unit cost for CPT code 77338 in the calculation of the CY 2011 median cost for APC 0310 because our estimated cost is not derived from claims and cost report data according to our standard process, and because we made several assumptions modeling a representative cost, such as whether the per unit cost for CPT code 77334 for treatment devices specific to IMRT patients was an appropriate proxy for the cost of each of the multiple devices, all of which would be reported by one unit of CPT code 77338. Moreover, we did not consider the other option that commenters recommended, using CY 2010 claims data to calculate a median cost for CPT code 77338, because costs estimated from CY 2010 claims would not be consonant with costs estimated from claims in CY 2009. Our standard methodology is to use the claims from the same year for all services to set the relative weights for payment under the OPPS. We believe that using claims from different years for different services has the potential to skew the relativity of the median costs on which the OPPS relative payment weights are based.

After consideration of the public comments we received and examination of updated CY 2009 claims data, we are reassigning CPT code 77338 from APC 0303 to APC 0310 for CY 2011. For CY 2012 OPPS ratesetting, we will have claims data for CPT code 77338. For CY 2012, we plan to use our standard cost estimation process using the CY 2010 claims data and the most recent cost report data to establish a median cost for CPT code 77338. In addition, we will assess whether placement of CPT code 77338 in APC 0310 remains appropriate for the CY 2012 OPPS.

d. High Dose Rate Brachytherapy (APC 0313)

For CY 2011, we proposed to include four CPT codes in APC 0313 (Brachytherapy). Specifically, APC 0313 would contain CPT codes 77785 (Remote afterloading high dose rate radionuclide brachytherapy; 1 channel), 77786 (Remote afterloading high dose rate radionuclide brachytherapy; 2–12

channels), 77787 (Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels), and 0182T (High dose rate electronic brachytherapy, per fraction). For the CY 2011 OPPS, the proposed APC median cost of APC 0313 was approximately $724.

Comment: One commenter objected to the proposed payment rate of approximately $724 for APC 0313 because it would be a reduction in payment from the CY 2010 payment rate of $777.55. The commenter questioned whether there was an error in the data or calculation of the proposed median cost for APC 0313. The commenter noted that, for the CY 2010 calculation of the median cost for APC 0313, deleted CPT code 77784 (Remote afterloading high intensity brachytherapy; over 12 source positions or catheters) had 7,577 total claims, while currently active CPT code 77787, which the commenter believes is analogous to CPT code 77784 in complexity, had only 1,899 CY 2010 proposed rule total claims. The commenter stated that, for the CY 2010 OPPS, deleted CPT code 77784, the most complex level of high intensity brachytherapy, accounted for 23.4 percent of the single bills used to calculate the median cost for APC 0313, while the most analogous currently active code, CPT code 77787, accounted for only 4.4 percent of the claims used to calculate the CY 2011 proposed median cost. The commenter suggested that the lower percentage of single frequency claims for CPT code 77787, which had a proposed rule median cost of approximately $812, resulted in a lower median cost for APC 0313. The commenter also noted that less than half of the total claims were used for CPT codes 77785 and 77786 in the proposed rule median cost calculations. The commenter asked that CMS check for possible errors in the calculation of the median cost and the payment rate for APC 0313 and that CMS closely monitor this APC.

Response: We have reviewed the CY 2011 final rule claims data for APC 0313, and we have not identified flaws in the data or the process we used to calculate the median cost of APC 0313. The CY 2011 final rule median cost for APC 0313 is approximately $693, and the median cost for CPT code 77785 is approximately $654 based on 11,075 single bills (out of a total frequency of 19,799 for CPT code 77785). For CPT code 77786, the median is approximately $748 based on 4,164 single bills (out of a total frequency of 9,421). For CPT code 77787, the median cost is approximately $811 based on 687 single bills (out of a total frequency of 2,149). For CPT code 0182T, the median cost is approximately $994 based on 101 single bills (out of a total frequency of 334).

The commenter is correct that the relative weights and median costs of the procedures that make up APC 0313 influence the overall APC median cost. However, some fluctuation in median costs across APCs is always present due to changes in hospital charging practices and costs. In addition, the CY 2011 median costs are based on CY 2009 claims. CPT codes 77785, 77786, and 77787 were new for CY 2009. Therefore, the charge for each of these codes represents a charge for a different combination of services than was true for the charges of the four CY 2008 predecessor codes on which the median costs for the CY 2010 OPPS were based. Hence, it is not clear to us that the medians from CY 2010 (based on charges for the four CY 2008 predecessor codes) and CY 2011 (based on charges for the first year for the new codes) can be appropriately compared. We have reviewed the claims and cost report data for APC 0313, and have found nothing that causes us to believe that the median costs at either the CPT code or APC level for APC 0313 are flawed.

After consideration of the public comments we received and analysis of our CY 2011 final rule claims data, we are finalizing our proposal to base the APC 0313 payment rate on its CY 2011 final rule median cost, which is approximately $693.

e. Electronic Brachytherapy (APC 0313)

The AMA CPT Editorial Panel created CPT code 0182T (High dose rate electronic brachytherapy, per fraction) effective July 1, 2007. We assigned CPT code 0182T to New Technology APC 1519 from July 1, 2007 through December 31, 2010, with a payment rate of $1,750. For CY 2010, we assigned CPT code 0182T to APC 0313 (Brachytherapy) because the CY 2010 OPPS final rule median cost for CPT code 0182T was approximately $506 and the final rule median cost for APC 0313, which contained services that we believed were clinically similar, was approximately $770. For CY 2011, we proposed to retain CPT code 0182T in APC 0313, with a proposed payment rate of approximately $710.

Comment: Several commenters recommended that CPT code 0182T be removed from APC 0313 and assigned its own APC. The commenters stated there are significant clinical differences between CPT code 0182T and the remaining three high dose rate (HDR) service codes in APC 0313: CPT code 77785 (Remote afterloading high dose rate radionuclide brachytherapy, 1 channel); CPT code 77786 (Remote afterloading high dose rate radionuclide brachytherapy, 2–12 channels); and CPT code 77787 (Remote afterloading high dose rate radionuclide brachytherapy, over 12 channels). However, the commenters did not provide a clinical rationale to support their statement. The commenters further stated that the total payment for CPT code 0182T is dissimilar to the total payment for CPT codes 77785, 77786, and 77787. They stated that CPT codes 77785, 77786, and 77787 are proposed to be paid both the APC 0313 payment rate, plus the payment rate for the separately paid brachytherapy source code C1717 (Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source), which had a proposed CY 2011 payment rate of approximately $220, thereby resulting in a total payment of approximately $949 for these codes. In contrast, the commenters stated that CMS does not allow providers to report the separate costs of the electronic brachytherapy source, but instead proposed to pay only the APC 0313 national unadjusted payment rate of approximately $710. The commenters believed that CMS should permit providers to capture the cost of the electronic brachytherapy source by establishing a separate APC for CPT code 0182T based on the median cost of CPT code 0182T alone.

Response: We believe the clinical characteristics of high dose rate brachytherapy and electronic brachytherapy are similar because both use brachytherapy to treat malignancies. Moreover, we do not agree that there is a need for an additional APC specific to electronic brachytherapy to "capture the cost of the electronic brachytherapy source" because there is no separate source in the case of electronic brachytherapy. The costs of electronic brachytherapy are included in the fractionated costs of the procedure.

The CY 2011 final rule median cost for CPT code 0182T of approximately $994, based on 101 single service claims, falls well within two times the APC 0313 median cost. The CY 2011 final rule APC 0313 median is approximately $693, based on 16,027 single bills for CPT codes 77785, 77786, 77787, and 0182T, which are assigned to APC 0313. We believe that CPT code 0182T is appropriately placed in APC 0313 for both resource and clinical reasons, as discussed above. We note that, in a system of averages, such as the OPPS, we expect that the cost of some services will fall above the APC median

cost and that the cost of other services will fall below the APC median cost.

After consideration of the public comments we received and analysis of the CY 2011 OPPS final rule claims data, we are assigning CPT code 0182T to APC 0313 for CY 2011. Based on the CY 2011 final rule claims data, we determined a median cost for CPT code 0182T of approximately $994 and a median cost for APC 0313 of approximately $693.

f. Tumor Imaging (APC 0406 and 0414)

For CY 2011, we proposed to assign CPT codes 78805 (Radiopharmaceutical localization of inflammatory process; limited area) and 78806 (Radiopharmaceutical localization of inflammatory process; whole body) to APC 0414 (Level II Tumor/Infection Imaging), with a proposed rule APC median cost of approximately $497. We proposed to assign CPT code 78807 (Radiopharmaceutical localization of inflammatory process; tomographic (SPECT)) to APC 0406 (Level I Tumor/Infection Imaging), with a proposed rule APC median cost of approximately $298. For CY 2011, CPT code 78805 had a proposed median cost of approximately $545; CPT code 78806 had a proposed median cost of approximately $561; and CPT code 78807 had a proposed median cost of approximately $442.

Comment: One commenter asked CMS to restructure APCs 0406 and 0414 to separate tumor imaging procedures from infection imaging procedures because the respective procedures use different drugs and resources. Specifically, the commenter recommended that CMS create a new APC for CPT codes 78805, 78806, and 78807 that would be for infection imaging.

Response: We continue to believe that tumor imaging and infection imaging are sufficiently clinically similar because they are all imaging services to justify the inclusion of CPT codes 78805, 78806, and 78807, which are for infection imaging, in APC 0414 with tumor imaging procedures. Therefore, we are not creating an APC that is limited to CPT codes 78805, 78806, and 78807 for infection imaging. However, after review of the CY 2011 OPPS final rule median costs for CPT codes 78805, 78806, and 78807, we believe that it is appropriate to reassign CPT code 78807 to APC 0414 (instead of APC 0406) for CY 2011 because the median cost for CPT code 78807 is similar to the median cost for CPT codes 78805 and 78806, which are also assigned to this APC. Based on the CY 2011 OPPS final rule claims data, CPT code 78805 has a median cost of approximately $519, CPT code 78806 has a median cost of approximately $539, and CPT code 78807 has a final rule median cost of approximately $428.

At its February 17–18, 2010 meeting, the APC Panel recommended that CMS analyze claims data for the tumor imaging APCs in terms of the average, median, and range of costs of packaged diagnostic radiopharmaceuticals. We are accepting the APC Panel's recommendation and will present the statistics regarding the use of diagnostic radiopharmaceuticals in tumor imaging at a forthcoming APC Panel meeting.

After consideration of the public comments we received and analysis of the final rule cost data for CPT codes 78805, 78806, and 78807, for CY 2011, we are retaining CPT codes 78805 and 78806 in APC 0414; we are assigning CPT code 78807 to APC 0414 (instead of APC 0406 as proposed); and we are basing the payment for APC 0414 on the CY 2011 final rule median cost of approximately $470.

6. Other Services

a. Skin Repair (APCs 0134 and 0135)

In the CY 2011 OPPS/ASC proposed rule (75 FR 46251), we proposed to continue to assign the CPT skin repair codes for the application of Apligraf, Oasis, and Dermagraft skin substitutes to the same procedural APCs to which they were assigned for CY 2010. Specifically, we proposed to continue to assign the Apligraf application CPT codes 15340 (Tissue cultured allogeneic skin substitute; first 25 sq cm or less) and 15341 (Tissue cultured allogeneic skin substitute; each additional 25 sq cm, or part thereof) to APC 0134 (Level II Skin Repair), with a proposed payment rate of approximately $217. Likewise, we proposed to continue to assign the Dermagraft application CPT codes 15365 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children) and 15366 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof) to APC 0134. We proposed to continue to assign the Oasis application CPT codes 15430 (Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children) and 15431 (Acellular xenograft implant; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof) to APC 0135 (Level III Skin Repair), with a proposed payment rate of approximately $318. In addition, we proposed to pay the Apligraf, Oasis, and Dermagraft skin substitutes separately. Specifically, we proposed to pay separately for the Apligraf skin product HCPCS Q-code Q4101 (Skin substitute, Apligraf, per square centimeter), the Dermagraft skin product HCPCS Q-code Q4106 ('Skin substitute, Dermagraft, per square centimeter), and the Oasis skin product HCPCS Q-codes Q4102 (Skin substitute, Oasis Wound Matrix, per square centimeter) and Q4103 (Skin substitute, Oasis burn matrix, per square centimeter), Also, as discussed in more detail below, we also proposed for CY 2011 to create two new Level II HCPCS G-codes to report the application of Apligraf or Dermagraft specific to the lower extremities in order to provide appropriate and consistent payment for these services as they are commonly furnished, consistent with the CY 2011 proposal for the MPFS.

With regard to the assignment of CPT codes 15340, 15341, 15365, 15366, 15430 and 15431, at the August 2009 APC Panel meeting, one public presenter requested that the APC Panel recommend that CMS reassign the Apligraf application CPT codes, specifically CPT codes 15340 and 15341, from APC 0134 to APC 0135. The same presenter requested that CMS continue to assign the Dermagraft application CPT codes, specifically CPT codes 15365 and 15366, to APC 0134. The public presenter believed that the CY 2010 proposal to continue to assign both the Apligraf and the Dermagraft application CPT codes to APC 0134 would create a financial incentive favoring the Dermagraft application. Specifically, the presenter explained that CPT instructions allow the separate reporting of the CPT codes for site preparation and debridement when Dermagraft is applied, while the CPT instructions for Apligraf application codes specify that site preparation and debridement cannot be separately reported. The presenter believed that this reporting difference and the resulting expected differences in the associated application procedure costs could be addressed by assigning the Apligraf application CPT codes to a higher paying APC than the Dermagraft application CPT codes, instead of the same APC as CMS proposed for CY 2010.

During the discussion, the APC Panel members were provided with the historical information on the coding and APC assignments for the skin substitute application procedures assigned to

APCs 0134 and 0135. Specifically, the Apligraf application CPT codes 15340 and 15341, the Dermagraft application CPT codes 15365 and 15366, as well as the Oasis application CPT codes 15430 and 15431, were at one time assigned to the same APC level (Level II Skin Repair). However, because of violations of the 2 times rule, CMS reconfigured the skin repair APCs and reassigned the Oasis application CPT codes 15430 and 15431 to APC 0135 in CY 2008.

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

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

At the February 2010 APC Panel meeting, CMS presented the results of the data requested at the August 2009 meeting to the APC Panel. In response to data on the frequency of primary and add-on CPT codes, based on our analysis of the available CY 2009 hospital outpatient claims data on frequency of primary and add-on CPT codes billed for the Apligraf, Oasis, and Dermagraft applications (claims processed from January 1 through September 30, 2009), we found that hospitals report the application of Apligraf with only the primary code (CPT code 15340) on 77 percent of claims, while the add-on CPT code 15341 is billed in addition to the primary code on another 23 percent of claims. Specifically, our data showed that, for the Apligraf application, there were a total of 8,614 claims with only the primary CPT code 15340 reported, and 2,545 claims with the add-on CPT code 15341 also reported on the same date of service. We note that each unit of the add-on CPT code is paid at 50 percent of the payment for the primary code in addition to the full payment for the primary code. We also found in our analysis that, on claims with the Dermagraft and Oasis application CPT codes, hospitals report the primary code only in approximately 98 to 99 percent of the cases. In addition, in response to the request for data for site preparation and debridement that may be reported separately for the Dermagraft application, we found that approximately 87 percent of procedures for the application of Dermagraft were reported without debridement or site preparation on the same day. Similarly, we found that the Apligraf and Oasis procedures were rarely reported with the site preparation or debridement CPT procedure codes on the same day. Specifically, we found that the CPT procedure code for the application of Apligraf was reported without site preparation or debridement in approximately 94 percent of these cases, and that the CPT procedure code for application of Oasis was reported without site preparation or debridement in approximately 95 percent of these cases. Our data analysis also showed that the CPT median costs for the Apligraf application CPT code 15340 and the Dermagraft application CPT code 15365 are very similar. Specifically, the CPT code-specific median cost of CPT code 15340 is approximately $234 for the Apligraf application and approximately $237 for CPT code 15365 for the Dermagraft application. In contrast, the CPT median cost for the Oasis application primary CPT code 15430 of approximately $299 is higher.

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

As noted above, in the CY 2011 OPPS/ASC proposed rule (75 FR 46251), we proposed to continue to assign the Apligraf application CPT codes 15340 and 15341 and the Dermagraft application CPT codes 15365 and 15366 to APC 0134, and, at the same time, continue to assign the Oasis application CPT codes 15430 and 15431 to APC 0135. Secondly, we proposed to continue to pay separately for the Apligraf, Dermagraft, and Oasis products in CY 2011.

Comment: One commenter disagreed with the APC assignment for the Apligraf CPT codes 15340 and 15341 and recommended a reassignment from APC 0134 to APC 0135.

Response: We examined the updated CY 2009 claims data available for the CY 2011 final rule with comment period and, based on the claims data, we believe that CPT codes 15340 and 15341 are appropriately placed in APC 0134. Specifically, our claims data show that the median cost of approximately $231 for CPT code 15340, based on 15,648 single claims (out of a total of 19,949 claims), and the median cost of approximately $189 for CPT code 15341, based on 2,621 single claims (out of a total of 5,468 claims), are relatively similar to the median cost of approximately $215 for APC 0134, and are dissimilar to the median cost of approximately $316 for APC 0135. Therefore, we are assigning CPT codes 15340 and 15341 to APC 0134 for CY 2011.

As noted above, we also proposed for CY 2011 to create two new Level II HCPCS G-codes to report the application of Apligraf or Dermagraft specific to the lower extremities in order to provide appropriate and consistent payment for these services as they are commonly furnished, consistent with

the CY 2011 proposal for the MPFS. (We refer readers to the CY 2011 MPFS proposed rule for additional information regarding the MPFS proposal and to the MPFS final rule for the final CMS decision regarding the use of these codes for the MPFS.) The proposed HCPCS codes were: GXXX1 (Application of tissue cultured allogeneic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; first 25 sq cm or less); and GXXX2 (Application of tissue cultured allogeneic skin or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; each additional 25 sq cm). We note that, for this CY 2011 OPPS/ASC final rule with comment period, GXXX1 has been designated as HCPCS code G0440 and HCPCS code GXXX2 as HCPCS code G0441. As indicated in the HCPCS G-code descriptors, these codes will not allow separate reporting of CPT codes for site preparation or debridement. In the proposed rule, we indicated that we believed the descriptors of the proposed HCPCS G-codes more specifically reflect the characteristics of the application of Apligraf or Dermagraft to the lower limb so that reporting would result in more accurate cost data for OPPS ratesetting and, ultimately, more appropriate payment. Consistent with the proposed CY 2011 APC assignment for the Apligraf and Dermagraft application CPT codes, we proposed to assign new HCPCS codes G0440 and G0441 to APC 0134, with a proposed APC median cost of approximately $222. We indicated that we were specifically interested in public comment on the appropriateness of recognizing these proposed new HCPCS G-codes under the OPPS and their proposed APC assignments.

Comment: Some commenters agreed with the establishment of HCPCS codes GXXX1 and GXXX2, and supported their APC assignment to APC 0134. One commenter suggested that, if CMS finalizes the proposal to establish the HCPCS G-codes, then it should recognize for CY 2011 the skin repair CPT codes, and also recommended that the HCPCS G-codes be assigned to APC 0135 rather than the proposed APC 0134. The commenter requested clarification on the definition of "dermal substitute."

However, many commenters disagreed with the establishment of the HCPCS G-codes. The commenters argued that, although they understood the need to report the services accurately, they did not believe that creating two HCPCS G-codes is appropriate because there are existing CPT codes that describe the application of both the Apligraf and Dermagraft. They stated that if a revision to the CPT code descriptors is necessary to accurately describe the services associated with these products, CMS should work with the AMA CPT Editorial Panel in making the revisions rather than creating two new HCPCS G-codes. One commenter stated that the inappropriate reimbursement for the application of these products is a MPFS issue and does not apply to the hospital OPPS. The commenter suggested that the proposed changes to create two HCPCS G-codes would cause providers to use the two more expensive products and, thereby, inadvertently create a competitive disadvantage for other products.

Response: We are persuaded from the commenters' statements that this is a payment issue that applies to the MPFS and not to the hospital OPPS, because the existing CPT codes for the application of these products does not impede our ability, under the standard OPPS ratesetting methodology, to calculate accurate median costs for these procedures and to assign them to appropriate APCs. Therefore, we are not finalizing our proposal to assign HCPCS G-codes G0440 and G0441 to APC 0134. For CY 2011, we are assigning the status indicators for both HCPCS G-codes to status indicator "B" to indicate that these HCPCS codes are not recognized under the hospital OPPS, and that hospitals should use a more specific HCPCS code(s) to describe the services associated with HCPCS codes G0440 and G0441.

With regard to the definition of "dermal substitute," we are directing our Medicare contractors to provide further guidance if specific questions arise.

After consideration of the public comments we received, we are finalizing our proposal, without modification, to continue to assign the Apligraf application CPT codes 15340 and 15341 and the Dermagraft application CPT codes 15365 and 15366 to APC 0134, with a final CY 2011 APC median cost of approximately $215 and to assign the Oasis application CPT codes 15430 and 15431 to APC 0135, with a final CY 2011 APC median cost of approximately $316. In addition, we received no comments on our proposal to continue to pay separately for the skin products. For CY 2011, we are finalizing our proposal, without modification, to continue to pay separately for the skin products, which are described by Level II HCPCS Q-codes. That is, we are finalizing our proposal to pay separately for the Apligraf skin product HCPCS Q-code Q4101, the Dermagraft skin product HCPCS Q-code Q4106, and the Oasis skin product HCPCS Q-codes Q4102 and Q4103. Further, HCPCS Q-codes Q4101, Q4102, Q4103, and Q4106 are assigned to status indicator "K" to indicate that they are separately payable under the hospital OPPS for CY 2011. In addition, we are not finalizing our proposal to recognize new HCPCS G-codes G0440 and G0441 as payable under the hospital OPPS. New HCPCS codes G0440 and G0441 are assigned to status indicator "B" to indicate that hospitals must report a more specific HCPCS code(s) to describe the services associated with HCPCS codes G0440 and G0441 for CY 2011.

b. Insertion of Anterior Segment Aqueous Drainage Device (APCs 0234, 0255, and 0673)

The AMA CPT Editorial Panel created Category III CPT code 0191T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach) effective on July 1, 2008. We assigned CPT code 0191T to APC 0234 (Level III Anterior Segment Eye Procedures) in the OPPS, effective July 1, 2008, and maintained this APC assignment for CY 2009 and CY 2010. For CY 2011, we proposed to continue to assign CPT code 0191T to APC 0234, with a proposed payment rate of approximately $1,674. For CY 2011, we also proposed to create new APC 0255 (Level III Anterior Segment Eye Procedures), and to rename APC 0234 as "Level IV Anterior Segment Eye Procedures" and APC 0673 as "Level V Anterior Segment Eye Procedures."

At its August 2010 meeting, the APC Panel recommended that CMS assign CPT code 0191T to APC 0673 (Level V Anterior Segment Eye Procedures), on the basis of its clinical similarity to both CPT code 0192T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach), and to CPT code 66180 (Aqueous shunt to extraocular reservoir (*e.g.,* Molteno, Schocket, Denver-Krupin)), which were proposed to be assigned to APC 0673 for CY 2011.

The AMA CPT Editorial Panel revised the descriptor of CPT code 0191T to "Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the trabecular meshwork," to be effective January 1, 2011.

Comment: A large number of commenters recommended that CMS reassign CPT code 0191T from APC 0234 to APC 0673, with a proposed CY 2011 payment rate of approximately $3,039. The commenters claimed that CPT code 0191T is more appropriately assigned to APC 0673 based on clinical

homogeneity and resource costs. They pointed out that none of the procedures in APC 0234 have implanted device costs associated with the procedures, except CPT code 0191T, while most procedures in APC 0673 have implanted device costs, including glaucoma procedures with implanted device costs, namely CPT code 66180 and CPT code 0192T. A few commenters claimed that each of the shunt devices in APC 0673 serve to shunt the aqueous fluid in the eye to another region in order to lower intraocular pressure, a common clinical purpose related to CPT code 0191T. Commenters asserted that the major cost of performing the procedure described by CPT code 0191T is the device itself, and that the proposed payment rate for APC 0234 is too low to compensate hospitals and ASCs for the cost of the procedure, thus preventing Medicare beneficiary access. Commenters also pointed out that cataract surgery is almost always performed with CPT code 0191T, as many cataract patients have mild to moderate glaucoma, resulting in a multiple procedure surgical session with a 50 percent multiple procedure reduction in payment for CPT code 0191T, which is predominantly performed in the ASC setting.

Many commenters asserted that the shunt device implantation performed with CPT code 0191T has much in common clinically with the implantation of the shunt device procedure performed with CPT code 0192T, which is assigned to APC 0673. Some commenters stated that the CPT code 0191T procedure is well within the skill set of a general ophthalmologist performing cataract surgery and promises to avoid some glaucoma medication usage.

One commenter argued that the resource costs of CPT code 0191T as demonstrated by CMS claims data is closer to the costs in APC 0673 than APC 0234, pointing out that the CY 2011 proposed rule median cost of approximately $2,964 for CPT code 0191T is appreciably higher than the range of costs of approximately $1,726 to approximately $2,026 for the 10 most frequent procedures in APC 0234. On the other hand, the commenter stated that the CY 2011 proposed rule median cost of CPT code 0191T is closer to the proposed rule median cost of approximately $3,099 for APC 0673 and the costs of its two most frequent procedures, that of CPT code 66180 (approximately $3,092) and CPT code 0192T (approximately $3,131). The commenter claimed that CMS has grouped clinically similar CPT codes together into an APC even though some services are significantly below the proposed APC costs. The commenter also noted that the procedure's device, the iStent Trabecular Micro-Bypass Stent (iStent), is currently under an investigational device exemption (IDE) and is awaiting full premarket approval (PMA) from the FDA, which it expects to receive by the end of 2011.

Response: After further analysis of this issue, we agree with the APC Panel and the commenters that CPT code 0191T is similar clinically and in terms of resource utilization to the procedures in APC 0673. Several procedures in APC 0673 have device implants that are related to glaucoma, such as CPT 0192T and CPT code 66180, and the CY 2011 final median cost for CPT code 0191T of approximately $3,139 is very similar to the median cost calculated for APC 0673 of approximately $2,946. Therefore, we are accepting the APC Panel's and the commenters' recommendation to reassign CPT code 0191T to APC 0673 for CY 2011.

After consideration of the public comments we received, we are modifying our CY 2011 proposal and reassigning CPT code 0191T to APC 0673 for CY 2011. We will continue to monitor claims and cost report data for CPT code 0191T in APC 0673.

c. Group Psychotherapy (APCs 0322, 0323, 0324, and 0325)

For CY 2011, we proposed to set the CY 2011 payment rates for APCs 0322 (Brief Individual Psychotherapy), 0323 (Extended Individual Psychotherapy), 0324 (Family Psychotherapy), and 0325 (Group Psychotherapy) based on the median costs determined under the OPPS standard ratesetting methodology. We also proposed to continue to assign CPT codes 90849 (Multiple family group psychotherapy), 90853 (Group psychotherapy (other than of a multiple-family group)), and 90857 (Interactive group psychotherapy) to APC 0325, with a proposed payment rate of approximately $54, calculated according to the standard OPPS ratesetting methodology. In CY 2010, these three CPT codes also were the only codes assigned to APC 0325, with a payment rate of approximately $60.

Comment: Some commenters expressed concern over the decreases in the proposed payment rates for APCs 0322, 0323, 0324, and 0325. Particularly, several commenters expressed concern that the CY 2011 proposed payment rate for APC 0325 of approximately $54 is 10 percent less than the CY 2010 payment rate for this APC. The commenters believed that the proposed payment rate would be insufficient to cover hospitals' costs for providing group mental health services and, as a result, would threaten Medicare beneficiary access to these services. Some commenters stated that the utilization of recent cost report data lags behind the provision of current services by approximately 3 to 5 years, and a stronger level of reimbursement would seem justified and appropriate.

Response: We set the payment rates for APCs 0322, 0323, 0324, and 0325 using our standard OPPS methodology based on relative costs from hospital outpatient claims and the most recent cost report data that are available. We have no reason to believe that our claims and cost report data, as reported by hospitals, do not accurately reflect hospitals' costs of the services assigned to these APCs. As we have stated in the past, specifically with respect to APC 0325 (72 FR 66739 and 73 FR 68627), we cannot speculate as to why the median cost of group psychotherapy services has decreased significantly in recent years. We again note that we have robust claims data for the CPT codes that map to APC 0325. Specifically, we were able to use more than 99 percent of the approximately 1.7 million claims submitted by hospitals to report group psychotherapy services. It would appear that the relative cost of providing these mental health services, in comparison with other HOPD services, has decreased in recent years.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to calculate the payment rate for APCs 0322, 0323, 0324, and 0325 by applying our standard OPPS ratesetting methodology that relies on all single claims for all procedures assigned to these APCs, and to continue to assign CPT codes 90849, 90853, and 90857 to APC 0325, with a final payment rate of approximately $54.

IV. OPPS Payment for Devices

A. Pass-Through Payments for Devices

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

Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This pass-through payment eligibility period begins with the first date on which transitional pass-through payments may be made for any medical device that is described by the category. We may establish a new device category for pass-through payment in any quarter. Under our established policy, we base the pass-through status expiration dates for the category codes

on the date on which a category is in effect. The date on which a category is in effect is the first date on which pass-through payment may be made for any medical device that is described by such category. We propose and finalize the dates for expiration of pass-through status for device categories as part of the OPPS annual update.

We also have an established policy to package the costs of the devices that are no longer eligible for pass-through payments into the costs of the procedures with which the devices are reported in the claims data used to set the payment rates (67 FR 66763). Brachytherapy sources, which are now separately paid in accordance with section 1833(t)(2)(H) of the Act, are an exception to this established policy.

There currently is one new device category eligible for pass-through payment, described by HCPCS code C1749 (Endoscope, retrograde imaging/illumination colonoscope device (implantable), which we announced in the October 2010 OPPS Update (Transmittal 2050, Change Request 7117, dated September 17, 2010). There are no categories for which we proposed expiration of pass-through status in CY 2011. If we create new device categories for pass-through payment status during the remainder of CY 2010 or during CY 2011, we will propose future expiration dates in accordance with the statutory requirement that they be eligible for pass-through payments for at least 2, but not more than 3, years from the date on which pass-through payment for any medical device described by the category may first be made.

Comment: Some commenters expressed concern that there currently are no pass-through categories for new devices, and that there have been very few new categories approved over the past several years. The commenters were concerned that CMS may not be recognizing technologies that demonstrate a substantial clinical improvement for Medicare beneficiaries, even though the commenters believed that there have been past applications that have met or exceeded that criterion. One commenter recommended that CMS reevaluate the criteria and approval process currently used for device pass-through applications. Another commenter believed that the need for separate payment for new technologies is even more acute because of the OPPS policy of increased packaging and bundled payment into composite APCs. One commenter recommended that CMS annually publish a list of all devices for which pass-through status was requested, along with the rationale supporting its decisions regarding approval or denial of pass-through status.

Response: The criteria for establishing additional pass-through categories for medical devices are included in the interim final rule with comment period issued in the November 2, 2001 **Federal Register** (66 FR 55850), the final rule with comment period issued in the November 1, 2002 **Federal Register** (67 FR 66781), and the November 10, 2005 OPPS final rule with comment period (70 FR 68628). We made no proposals regarding our device pass-through process or criteria for CY 2011. However, industry members have, from time to time, requested that we provide additional information on our new technology processes, which we have attempted to do in the past. We agree with the commenters that separate payment for new technologies through the device pass-through process is an important feature of the OPPS, and we continue to review applications on an ongoing basis using our established process and criteria and to establish new categories of pass-through devices when those criteria are met. We disagree with the commenters who believe that we may not be recognizing technologies that demonstrate a substantial clinical improvement. We carefully evaluate each application based on the established criteria, including whether the device demonstrates a substantial clinical improvement.

We are not making any changes to the device pass-through process or criteria in this final rule with comment period because we believe any changes would require public input, including input from affected parties, and, therefore, should be addressed through our rulemaking cycle. For example, while some parties may approve of putting specific information about pass-through applications on our Web site, such as the basis for an application's denial, others who request that we treat all or part of their applications as confidential may not support such a change in the pass-through process. (We note that filing an application to CMS does not guarantee that CMS is able to treat any information as confidential because such information is used as part of the OPPS ratesetting process.) However, we do appreciate the commenters' perspectives and will take their comments under advisement as we consider our device pass-through criteria and process in the future.

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

a. Background

We have an established policy to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of the associated devices that are eligible for pass-through payments (66 FR 59904). We deduct from the pass-through payments for identified device categories eligible for pass-through payments an amount that reflects the portion of the APC payment amount that we determine is associated with the cost of the device, defined as the device APC offset amount, as required by section 1833(t)(6)(D)(ii) of the Act. We have consistently employed an established methodology to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment, using claims data from the period used for the most recent recalibration of the APC rates (72 FR 66751 through 66752). We establish and update the applicable device APC offset amounts for eligible pass-through device categories through the transmittals that implement the quarterly OPPS updates.

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

As of CY 2009, the costs of implantable biologicals without pass-through status are packaged into the payment for the procedures in which they are inserted or implanted because implantable biologicals without pass-through status are not separately paid (73 FR 68633 through 68636). For CY 2010, we finalized a new policy to specify that the pass-through evaluation process and pass-through payment methodology for implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that are newly approved for pass-through status beginning on or after January 1, 2010, be the device pass-through process and payment methodology only. As a result, for CY 2010, we included implantable

biologicals in our calculation of the device APC offset amounts (74 FR 60476). We calculated and set the device APC offset amount for a newly established device pass-through category, which could include a newly eligible implantable biological, beginning in CY 2010 using the same methodology we have historically used to calculate and set device APC offset amounts for device categories eligible for pass-through payment (72 FR 66751 through 66752), with one modification. Because implantable biologicals are considered devices rather than drugs for purposes of pass-through evaluation and payment under our established policy, the device APC offset amounts include the costs of implantable biologicals. For CY 2010, we also finalized a policy to utilize the revised device APC offset amounts to evaluate whether the cost of an implantable biological in an application for a new device category for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the category of devices. Further, for CY 2010, we also no longer used the "policy-packaged" drug APC offset amounts for evaluating the cost significance of implantable biological pass-through applications under review and for setting the APC offset amounts that would apply to pass-through payment for those implantable biologicals, effective for new pass-through status determinations beginning in CY 2010 (74 FR 60463).

b. Proposed and Final CY 2011 Policy

In the CY 2011 OPPS/ASC proposed rule (75 FR 46252), we proposed to continue our policy that the pass-through evaluation process and pass-through payment methodology for implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that are newly approved for pass-through status beginning on or after January 1, 2010, be the device pass-through process and payment methodology only. The rationale for this policy is provided in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60471 through 60477). We also proposed to continue our established policies for calculating and setting the device APC offset amounts for each device category eligible for pass-through payment. In addition, we proposed to continue to review each new device category on a case-by-case basis to determine whether device costs associated with the new category are already packaged into the existing APC structure. If device costs packaged into the existing APC structure are associated with the new category, we would deduct the device APC offset amount from the pass-through payment for the device category. As stated earlier, these device APC offset amounts also would be used in order to evaluate whether the cost of a device in an application for a new device category for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the category of devices (§ 419.66(d)).

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

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

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

Comment: Some commenters recommended that CMS not continue the policy it began for CY 2010 to specify that the pass-through evaluation process and pass-through payment methodology for implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) be the device pass-through process and payment methodology only. One commenter asserted that some implantable biologicals meet the definition of biological under section 1861(t) of the Act, even though they are approved by the FDA as devices. The commenter recommended that biologicals approved by the FDA under a biologics license application (BLA) should be eligible for pass-through payment under the drug and nonimplantable biological pass-through process, regardless of whether or not they are implanted. The commenter claimed that Congress intended for biologicals approved under BLAs to be paid as pass-through drugs because the commenter believed that Congress intended that biologicals be included under the specific OPPS statutory provisions that apply to specified covered outpatient drugs (SCODs). The commenter alternatively requested that if CMS continues to define implantable biologicals as devices for pass-through purposes, CMS clarify that it will apply device process and payment only if the devices are solely surgically implanted according to their FDA-approved indications. The commenter claimed that the current pass-through policy is unclear regarding how CMS would evaluate eligibility for pass-through payment of a biological that has both implantable and nonimplantable indications.

Another commenter believed that CMS has not sufficiently defined the term "surgically inserted or implanted" regarding applicability of pass-through device process and payment for implantable biologicals. The commenter questioned whether biologicals inserted into the body via catheter (which requires a surgical incision to place a catheter) or an injection of a biological administered through a natural orifice should be considered implantable biologicals. The commenter asked whether a biological that is inserted into the body as a drug administration, that is, by means of injection or infusion, is considered surgically inserted or implanted for purposes of pass-through status evaluation and payment. The commenter also recommended paying for implantable biologicals using the

drug payment methodology, proposed at ASP plus 6 percent, rather than the current methodology of charges adjusted to costs. The commenter asserted the advantages of the ASP payment methodology are as follows: there would be identical payment methodologies for biologicals that function as both implantable and nonimplantable biologicals; the ASP methodology is well-understood by providers and contractors; the ASP methodology avoids the problem of hospitals being reluctant to mark up charges for new implantable biologicals, thereby resulting in charge compression and an underestimation of costs; and the ASP methodology assures a consistent payment method, rather than the hospital-specific, charges-adjusted-to-cost methodology.

Response: As stated in the CY 2010 OPPS/ASC final rule with comment period, we evaluate implantable biologicals that function as and are substitutes for implantable devices, regardless of their category of FDA approval, as devices for OPPS payment purposes (74 FR 60476). We do not believe it is necessary to make our OPPS payment policies regarding implantable biologicals dependent on categories of FDA approval, the intent of which is to ensure the safety and effectiveness of medical products.

We do not agree with the commenter who asserted that Congress intended biologicals approved under BLAs to be paid under the specific OPPS statutory provisions that apply to SCODs, including the pass-through provisions. Moreover, as we stated in the CY 2010 OPPS/ASC final rule with comment period, Congress did not specify that we must pay for implantable biologicals as biologicals rather than devices, if they also meet our criteria for payment as a device (74 FR 60476). We continue to believe that implantable biologicals meet the definitions of a device and a biological and that, for payment purposes, it is appropriate for us to consider implantable biologicals as implantable devices in all cases, not as biologicals.

We also do not agree with the commenter's request that we pay for pass-through implantable biologicals using the ASP payment methodology. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60474), we do not believe that this payment methodology would be appropriate because payment based on ASP for pass-through implantable biologicals would not provide similar OPPS payment treatment of biological and nonbiological implantable devices, which is our goal for new devices. Given the shared payment methodologies for implantable biological and nonbiological devices during their nonpass-through payment periods, as well as their overlapping and sometimes identical clinical uses and their generally similar regulation by the FDA as devices, we continue to believe that the most consistent pass-through payment policy for these different types of items that are surgically inserted or implanted and that may sometimes substitute for one another is to evaluate and pay for all of these devices, both biological and nonbiological, only under the device pass-through payment and methodology.

Regarding the comment that claimed we have not sufficiently defined the term "surgically inserted or implanted" regarding applicability of pass-through device process and payment for implantable biologicals, we believe that infusion or injection of a biological product through a catheter is generally not considered implantation of a device since these products are being administered through a catheter rather than inserted or implanted into the body, in the same way that we have stated in the past with respect to drug and device combination products that it is not our intention to consider biologicals under the device pass-through evaluation process when these products are merely administered through the implantation of a delivery system for the biological (74 FR 60476). We believe that applicants seeking pass-through payment for a particular technology must determine whether to apply through the drug or device pass-through process based on how the individual product will be administered.

In response to the comment seeking clarity regarding how CMS would evaluate eligibility for pass-through payment of a biological that has both implantable and non-implantable indications, we again note that applicants for pass-through status must determine whether to apply through the drug or device pass-through process based on how the individual product will be used. If we were to receive applications for the same product for both drug pass-through status and device pass-through status, and if both applications met the respective criteria for approval, we would evaluate how it is administered in order to determine whether it would be appropriate to differentiate the payment methodology for the product depending on how it is used, as we do for nonpass-through biologicals that may be sometimes used as drugs, and sometimes used as devices.

After consideration of the public comments we received, we are finalizing our proposal, without modification, to continue the policy to specify that the pass-through evaluation process and pass-through payment methodology for implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that are newly approved for pass-through status on or after January 1, 2010, be the device pass-through process and payment methodology only. We also are finalizing our other proposals, without modification, to continue the following policies regarding device offsets: (1) Including implantable biologicals in calculating the device APC offset amounts; (2) using the device APC offset amounts to evaluate whether the cost of a device (defined to include implantable biologicals) in an application for a new device category for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the category of devices; and (3) reducing device pass-through payments based on device costs already included in the associated procedural APCs, when we determine that device costs associated with the new category are already packaged into the existing APC structure.

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

1. Background

In recent years, there have been several field actions on and recalls of medical devices as a result of implantable device failures. In many of these cases, the manufacturers have offered devices without cost to the hospital or with credit for the device being replaced if the patient required a more expensive device. In order to ensure that payment rates for procedures involving devices reflect only the full costs of those devices, our standard ratesetting methodology for device-dependent APCs uses only claims that contain the correct device code for the procedure, do not contain token charges, do not contain the "FB" modifier signifying that the device was furnished without cost or with a full credit, and do not contain the "FC" modifier signifying that the device was furnished with partial credit. As discussed in section II.A.2.d.(1) of this final rule with comment period, as we proposed, we are continuing to use our standard ratesetting methodology for device-dependent APCs for CY 2011.

To ensure equitable payment when the hospital receives a device without

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

2. APCs and Devices Subject to the Adjustment Policy

In the CY 2011 OPPS/ASC proposed rule (75 FR 46253 through 46256), we proposed to continue for CY 2011 the existing policy of reducing OPPS payment for specified APCs by 100 percent of the device offset amount when a hospital furnishes a specified device without cost or with a full credit and by 50 percent of the device offset amount when the hospital receives partial credit in the amount of 50 percent or more of the cost for the specified device. Because the APC payments for the related services are specifically constructed to ensure that the full cost of the device is included in the payment, we stated in the CY 2011 OPPS/ASC proposed rule (75 FR 46253) that we continue to believe it is appropriate to reduce the APC payment in cases in which the hospital receives a device without cost, with full credit, or with partial credit, in order to provide equitable payment in these cases. (We refer readers to section II.A.2.d.(1) of this final rule with comment period for a description of our standard rate-setting methodology for device-dependent APCs). Moreover, the payment for these devices comprises a large part of the APC payment on which the beneficiary copayment is based, and we continue to believe it is equitable that the beneficiary cost sharing reflects the reduced costs in these cases.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46253), we also proposed to continue using the three criteria established in the CY 2007 OPPS/ASC final rule with comment period for determining the APCs to which this policy applies (71 FR 68072 through 68077). Specifically: (1) All procedures assigned to the selected APCs must involve implantable devices that would be reported if device insertion procedures were performed; (2) the required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedure (at least temporarily); and (3) the device offset amount must be significant, which, for purposes of this policy, is defined as exceeding 40 percent of the APC cost. We proposed to continue to restrict the devices to which the APC payment adjustment would apply to a specific set of costly devices to ensure that the adjustment would not be triggered by the implantation of an inexpensive device whose cost would not constitute a significant proportion of the total payment rate for an APC. We stated in the CY 2011 OPPS/ASC proposed rule (75 FR 46253) that we continue to believe these criteria are appropriate because free devices and device credits are likely to be associated with particular cases only when the device must be reported on the claim and is of a type that is implanted and remains in the body when the beneficiary leaves the hospital. We believe that the reduction in payment is appropriate only when the cost of the device is a significant part of the total cost of the APC into which the device cost is packaged, and that the 40-percent threshold is a reasonable definition of a significant cost.

As indicated in the CY 2011 OPPS/ASC proposed rule (75 FR 46253), we examined the offset amounts calculated from the CY 2011 proposed rule data and the clinical characteristics of APCs to determine whether the APCs to which the no cost/full credit and partial credit device adjustment policy applies in CY 2010 continue to meet the criteria for CY 2011, and to determine whether other APCs to which the policy does not apply in CY 2010 would meet the criteria for CY 2011. Based on the CY 2009 claims data available for the proposed rule, we did not propose any changes to the APCs and devices to which this policy applies. Table 18 of the CY 2011 OPPS/APC proposed rule (75 FR 46254) listed the proposed APCs to which the payment adjustment policy for no cost/full credit and partial credit devices would apply in CY 2011 and displayed the proposed payment adjustment percentages for both no cost/full credit and partial credit circumstances. We proposed that the no cost/full credit adjustment for each APC to which this policy would continue to apply would be the device offset percentage for the APC (the estimated percentage of the APC cost that is attributable to the device costs that are packaged into the APC). We also proposed that the partial credit device adjustment for each APC would continue to be 50 percent of the no cost/full credit adjustment for the APC. Table 19 of the CY 2011 OPPS/APC proposed rule (75 FR 46256) listed the proposed devices to which the payment adjustment policy for no cost/full credit and partial credit devices would apply in CY 2011. We stated in the CY 2011 proposed rule (75 FR 46253) that we would update the lists of APCs and devices to which the no cost/full credit and partial credit device adjustment policy would apply for CY 2011, consistent with the three selection criteria discussed earlier in this section, based on the final CY 2009 claims data available for the CY 2011 OPPS/ASC final rule with comment period.

Comment: One comment supported the 40-percent threshold as a reasonable definition of significant cost when determining the APCs to which the no cost/full credit and partial device adjustment policy applies. However, the commenter expressed concern about the application of this standard and questioned how CMS determines which

APCs meet the threshold based on claims data. The commenter also expressed concern that, for implantable orthopedic devices in particular, the existing codes do not include all of the devices currently being used. The commenter stated that currently available HCPCS codes do not comprehensively describe all implantable devices, and that this may negatively impact calculations of the device offset. For example, the commenter indicated that a large number of implantable devices are reported using HCPCS code C1713 (Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)). The commenter recommended that CMS evaluate the adequacy of the device codes to facilitate accurate tracking and cost estimation.

Response: We appreciate the commenter's support for the 40 percent threshold as a reasonable definition of significant cost. As described in the CY 2007 OPPS final rule with comment period (71 FR 68063 through 68066), we calculate the APC offset amount used to determine which APCs meet the 40-percent threshold by first calculating an APC median cost including device costs and then calculating an APC median cost excluding device costs using single bills that contain devices.

The device cost is estimated from the device HCPCS codes present on the claims and charges in the lines for four specific revenue codes: 275 (Medical/Surgical Supplies: Pacemaker), 276 (Medical/Surgical Supplies: Intraocular lens), 278 (Medical/Surgical Supplies: Other implants), and 624 (Medical/Surgical Supplies: FDA investigational devices). We then divide the "without device" median cost by the "with device" median cost and subtract the percent from 100 to acquire the percent of cost attributable to devices in the APC.

We do not agree with the commenter that the available HCPCS codes are not sufficiently specific to allow hospitals to accurately report charges for implantable devices on their claims and for us to derive accurate device offset amount estimates from those claims. We are aware that devices of varying description and cost are billed with individual device category codes, such as HCPCS code C1713, but we do not believe that this limits hospitals' ability to report accurate costs and charges for items that may be described by those codes. Hospitals must determine how best to accurately report costs and charges for all items and services they provide, such as assigning device charges to a C-code or an uncoded revenue line. As described above, we use both the C-codes and uncoded revenue lines to calculate the device offset.

After consideration of the public comment we received, we are finalizing our CY 2011 proposals, without modification, to continue the established no cost/full credit and partial credit adjustment policy. Table 25 below lists the APCs to which the payment adjustment policy for no cost/full credit and partial credit devices will apply in CY 2011 and displays the final payment adjustment percentages for both no cost/full credit and partial credit circumstances. Table 26 below lists the devices to which no cost/full credit and partial credit device adjustment policy will apply for CY 2011, consistent with the three selection criteria discussed earlier in this section, based on the final CY 2009 claims data available for this final rule with comment period. For CY 2011, OPPS payments for implantation procedures to which the "FB" modifier is appended are reduced by 100 percent of the device offset for no cost/full credit cases when both a device code listed in Table 26 below, is present on the claim and the procedure code maps to an APC listed in Table 25 below. OPPS payments for implantation procedures to which the "FC" modifier is appended are reduced by 50 percent of the device offset when both a device code listed in Table 26 is present on the claim and the procedure code maps to an APC listed in Table 25. Beneficiary copayment is based on the reduced amount when either the "FB" modifier or the "FC" modifier is billed and the procedure and device codes appear on the lists of procedures and devices to which this policy applies.

We note that we are adding one new APC for CY 2011 to Table 25, APC 0318 (Implantation of Cranial Neurostimulator Pulse Generator and Electrode), and deleting APC 0225 (Implantation of Neurostimulator Electrodes, Cranial Nerve). As discussed in section II.A.2.d.9. of this final rule with comment period, we are making changes to these device-dependent APCs in order to accommodate revisions to coding in CY 2011.

TABLE 25—APCS TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY WILL APPLY IN CY 2011

Final CY 2011 APC	CY 2011 APC Title	Final CY 2011 device offset percentage for no cost/full credit case	Final CY 2011 device offset percentage for partial credit case
0039	Level I Implantation of Neurostimulator Generator	86	43
0040	Percutaneous Implantation of Neurostimulator Electrodes	58	29
0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes	64	32
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	71	35
0090	Insertion/Replacement of Pacemaker Pulse Generator	73	36
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	46	23
0107	Insertion of Cardioverter-Defibrillator	88	44
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	87	44
0227	Implantation of Drug Infusion Device	81	41
0259	Level VII ENT Procedures	85	43
0315	Level II Implantation of Neurostimulator Generator	88	44
0318	Implantation of Cranial Neurostimulator Pulse Generator and Electrode	85	43
0385	Level I Prosthetic Urological Procedures	61	31
0386	Level II Prosthetic Urological Procedures	71	36
0418	Insertion of Left Ventricular Pacing Elect	73	36
0425	Level II Arthroplasty or Implantation with Prosthesis	59	30
0648	Level IV Breast Surgery	46	23
0654	Insertion/Replacement of a permanent dual chamber pacemaker	74	37
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	74	37

TABLE 25—APCS TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY WILL APPLY IN CY 2011—Continued

Final CY 2011 APC	CY 2011 APC Title	Final CY 2011 device offset percentage for no cost/full credit case	Final CY 2011 device offset percentage for partial credit case
0680	Insertion of Patient Activated Event Recorders	71	35

TABLE 26—DEVICES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY WILL APPLY IN CY 2011

CY 2011 device HCPCS code	CY 2011 short descriptor
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1728	Cath, brachytx seed adm.
C1764	Event recorder, cardiac.
C1767	Generator, neurostim, imp.
C1771	Rep dev, urinary, w/sling.
C1772	Infusion pump, programmable.
C1776	Joint device (implantable).
C1777	Lead, AICD, endo single coil.
C1778	Lead, neurostimulator.
C1779	Lead, pmkr, transvenous VDD.
C1785	Pmkr, dual, rate-resp.
C1786	Pmkr, single, rate-resp.
C1789	Prosthesis, breast, imp.
C1813	Prosthesis, penile, inflatab.
C1815	Pros, urinary sph, imp.
C1820	Generator, neuro rechg bat sys.
C1881	Dialysis access system.
C1882	AICD, other than sing/dual.
C1891	Infusion pump, non-prog, perm.
C1895	Lead, AICD, endo dual coil.
C1896	Lead, AICD, non sing/dual.
C1897	Lead, neurostim, test kit.
C1898	Lead, pmkr, other than trans.
C1899	Lead, pmkr/AICD combination.
C1900	Lead coronary venous.
C2619	Pmkr, dual, non rate-resp.
C2620	Pmkr, single, non rate-resp.
C2621	Pmkr, other than sing/dual.
C2622	Prosthesis, penile, non-inf.
C2626	Infusion pump, non-prog, temp.
C2631	Rep dev, urinary, w/o sling.
L8600	Implant breast silicone/eq.
L8614	Cochlear device/system.
L8680	Implt neurostim elctr each.
L8685	Implt nrostm pls gen sng rec.
L8686	Implt nrostm pls gen sng non.
L8687	Implt nrostm pls gen dua rec.
L8688	Implt nrostm pls gen dua non.
L8690	Aud osseo dev, int/ext comp.

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

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

1. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or "transitional pass-through payments" for certain drugs and biologicals (also referred to as biologics). As enacted by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113), this provision requires the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act (Pub. L. 107–186); current drugs and biologicals and brachytherapy sources used for the treatment of cancer; and current radiopharmaceutical drugs and biologicals. For those drugs and biologicals referred to as "current," the transitional pass-through payment began on the first date the hospital OPPS was implemented.

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

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

This methodology for determining the pass-through payment amount is set forth in regulations at 42 CFR 419.64, which specify that the pass-through payment equals the amount determined under section 1842(o) of the Act minus the portion of the APC payment that CMS determines is associated with the drug or biological. Section 1847A of the Act establishes the use of the average sales price (ASP) methodology as the basis for payment for drugs and biologicals described in section 1842(o)(1)(C) of the Act that are furnished on or after January 1, 2005. The ASP methodology, as applied under the OPPS, uses several sources of data as a basis for payment, including the ASP, the wholesale acquisition cost (WAC), and the average wholesale price (AWP). In this final rule with comment period, the term "ASP methodology" and "ASP-based" are inclusive of all data sources and methodologies described therein. Additional information on the ASP methodology can be found on the CMS Web site at: *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice.*

As noted above, section 1833(t)(6)(D)(i) of the Act also provides that, if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and the year established as calculated and adjusted by the Secretary. Section 1847B of the Act establishes the payment methodology for Medicare Part B drugs and biologicals under the competitive acquisition program (CAP). The Part B drug CAP was implemented on July 1, 2006, and included approximately 190 of the most common Part B drugs provided in the physician's office setting. As we noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68633), the Part B drug CAP program was postponed beginning in CY 2009 (Medicare Learning Network (MLN) Matters Special Edition 0833, available via the Web site: *http://www.medicare.gov*). As

of publication of this final rule with comment period, the postponement of the Part B drug CAP program remains in effect and, there is no effective CAP program rate for pass-through drugs and biologicals as of January 1, 2009. Consistent with what we indicated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60466), if the program is reinstituted during CY 2011 and Part B drug CAP rates become available, we would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program. Otherwise, we would continue to use the rate that would be paid in the physician's office setting for drugs and biologicals with pass-through status.

For CYs 2005, 2006, and 2007, we estimated the OPPS pass-through payment amount for drugs and biologicals to be zero based on our interpretation that the "otherwise applicable Medicare OPD fee schedule" amount was equivalent to the amount to be paid for pass-through drugs and biologicals under section 1842(o) of the Act (or section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract). We concluded for those years that the resulting difference between these two rates would be zero. For CYs 2008 and 2009, we estimated the OPPS pass-through payment amount for drugs and biologicals to be $6.6 million and $23.3 million, respectively. For CY 2010, we estimated the OPPS pass-through payment estimate for drugs and biologicals to be $35.5 million. Our OPPS pass-through payment estimate for drugs and biologicals in CY 2011 is $15.5 million, which is discussed in section VI.B. of this final rule with comment period.

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

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46257 through 46258), we proposed that the pass-through status of 18 drugs and biologicals would expire on December 31, 2010, as listed in Table 20 of the proposed rule (75 FR 46258). All of these drugs and biologicals will have received OPPS pass-through payment for at least 2 years, and no more than 3 years, by December 31, 2010. These drugs and biologicals were approved for pass-through status on or before January 1, 2009. With the exception of those groups of drugs and biologicals that are always packaged when they do not have pass-through status, specifically diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals, our standard methodology for providing payment for drugs and biologicals with expiring pass-through status in an upcoming calendar year is to determine the product's estimated per day cost and compare it with the OPPS drug packaging threshold for that calendar year (which is $70 for CY 2011), as discussed further in section V.B.2. of this final rule with comment period. If the drug's or biological's estimated per day cost is less than or equal to the applicable OPPS drug packaging threshold, we would package payment for the drug or biological into the payment for the associated procedure in the upcoming calendar year. If the estimated per day cost of the drug or biological is greater than the OPPS drug packaging threshold, we would provide separate payment at the applicable relative ASP-based payment amount (which is at ASP+5 percent for CY 2011, as discussed further in section V.B.3. of this final rule with comment period). Section V.B.2.d. of this final rule with comment period discusses the packaging of all nonpass-through contrast agents, diagnostic radiopharmaceuticals, and implantable biologicals.

Two of the products for which we proposed to expire pass-through status in CY 2011 are biologicals that are solely surgically implanted according to their Food and Drug Administration approved indications. As discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60467), we package payment for those implantable biologicals that have expiring pass-though status into payment for the associated surgical procedure. In the CY 2011 OPPS/ASC proposed rule, we proposed to package payment for two products described by HCPCS codes C9356 (Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter) and C9359 (Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc).

To date, for other nonpass-through biologicals paid under the OPPS that may sometimes be used as implantable devices, we have instructed hospitals, via Transmittal 1336, Change Request 5718, dated September 14, 2007, to not separately bill for drug and biological HCPCS codes for the biologicals when they are used as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. When using drugs and biologicals during surgical procedures as implantable devices, hospitals may include the charge for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code if one exists, so the costs would appropriately contribute to the future median setting for the associated procedure. In such cases, we consider payment for the biological used as an implantable device in a specific clinical case to be included in payment for the surgical procedure.

As we established in the CY 2003 OPPS final rule with comment period (67 FR 66763), when the pass-through payment period for an implantable device ends, it is standard OPPS policy to package payment for the implantable device into payment for its associated surgical procedure. We consider nonpass-through implantable devices to be integral and supportive items and services for which packaged payment is most appropriate. According to our regulations at § 419.2(b), as a prospective payment system, the OPPS establishes a national payment rate that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis including, but not limited to, implantable prosthetics, implantable durable medical equipment, and medical and surgical supplies. Therefore, when the period of nonbiological device pass-through payment ends, we package the costs of the devices no longer eligible for pass-through payment into the costs of the procedures with which the devices were reported in the claims data used to set the payment rates for the upcoming calendar year. As described in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68634), we believed that this policy to package payment for implantable devices that are integral to the performance of separately paid procedures should also apply to payment for implantable biologicals without pass-through status, when those biologicals are used as implantable devices. As stated above, implantable biologicals may be used in place of other implantable nonbiological devices whose costs are already accounted for in the associated procedural APC payments for surgical procedures. If we were to provide separate payment for these implantable

biologicals without pass-through status, we would potentially be providing duplicate device payment, both through the packaged nonbiological device cost included in the surgical procedure's payment and separate biological payment. We indicated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68634) that we saw no basis for treating implantable biological and nonbiological devices without pass-through status differently for OPPS payment purposes because both are integral to and supportive of the separately paid surgical procedures in which either may be used.

We did not receive any public comments on our proposal to expire the 18 drugs and biologicals that were identified in the proposed rule from pass-through status, effective December 31, 2010. We are finalizing our proposal, without modification, to expire the pass-through status of the 18 drugs and biologicals listed in Table 27 below, effective December 31, 2010.

TABLE 27—DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS WILL EXPIRE DECEMBER 31, 2010

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

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46258), we proposed to continue pass-through status in CY 2011 for 31 drugs and biologicals. None of these drugs and biologicals will have received OPPS pass-through payment for at least 2 years and no more than 3 years by December 31, 2010. These drugs and biologicals, which were approved for pass-through status between April 1, 2009 and July 1, 2010, were listed in Table 21 of the proposed rule. The APCs and HCPCS codes for these drugs and biologicals were assigned status indicator "G" in Addenda A and B to the proposed rule (75 FR 46259).

Section 1833(t)(6)(D)(i) of the Act sets the amount of pass-through payment for pass-through drugs and biologicals (the pass-through payment amount) as the difference between the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a CAP under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and the year established under such section as calculated and adjusted by the Secretary) and the portion of the otherwise applicable OPD fee schedule that the Secretary determines is associated with the drug or biological. Payment for drugs and biologicals with pass-through status under the OPPS is currently made at the physician's office payment rate of ASP+6 percent. In the proposed rule, we stated that we believe it is consistent with the statute to continue to provide payment for drugs and biologicals with pass-through status at a rate of ASP+6 percent in CY 2011, the amount that drugs and biologicals receive under section 1842(o) of the Act. Thus, for CY 2011, we proposed to pay for pass-through drugs and biologicals at ASP+6 percent, equivalent to the rate these drugs and biologicals would receive in the physician's office setting in CY 2011. We proposed that a zero pass-through payment amount would be paid for most pass-through drugs and biologicals under the CY 2011 OPPS because the difference between the amount authorized under section 1842(o) of the Act, which is ASP+6 percent, and the portion of the otherwise applicable OPD fee schedule that the Secretary determines is appropriate, proposed at ASP+6 percent, is zero. In the case of pass-through contrast agents, diagnostic radiopharmaceuticals, and implantable biologicals, their pass-through payment amount would be equal to ASP+6 percent because, if not on pass-through status, payment for these products would be packaged into the associated procedures.

In addition, we proposed to continue to update pass-through payment rates on a quarterly basis on the CMS Web site during CY 2011, if later quarter ASP submission (or more recent WAC or AWP information, as applicable) indicate that adjustments to the payment rates for these pass-through drugs or biologicals are necessary. For a full description of this policy, we refer readers to the CY 2006 OPPS/ASC final rule with comment period (70 FR 42722 and 42723). If the Part B drug CAP is reinstated during CY 2011, and a drug or biological that has been granted pass-

through status for CY 2011 becomes covered under the Part B drug CAP, we proposed to provide pass-though payment at the Part B drug CAP rate and to make the adjustments to the payment rates for these drugs and biologicals on a quarterly basis, as appropriate. As is our standard methodology, we annually review new permanent HCPCS codes and delete temporary HCPCS C-codes if an alternate permanent HCPCS code is available for purposes of OPPS billing and payment.

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

As discussed in more detail in section V.B.2.d. of this final rule with comment period, over the last 3 years, we implemented a policy whereby payment for all nonpass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals is packaged into payment for the associated procedure. In the CY 2011 OPPS/ASC proposed rule (75 FR 46271), we proposed to continue the packaging of these items, regardless of their per day cost, in CY 2011. As stated earlier, pass-through payment is the difference between the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a CAP under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and the year established under such section as calculated and adjusted by the Secretary) and the portion of the otherwise applicable OPD fee schedule that the Secretary determines is associated with the drug or biological. Because payment for a drug that is either a diagnostic radiopharmaceutical or a contrast agent (identified as a "policy-packaged" drug, first described in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68639)) or for an implantable biological (which we consider to be a device when it functions as an implantable device for all payment purposes, as discussed in sections V.A.4. and V.B.2.d. of the CY 2010 OPPS/ASC final rule with comment period (74 FR 60458)) would otherwise be packaged if the product did not have pass-through status, we believe the otherwise applicable OPPS payment amount would be equal to the "policy-packaged" drug or device APC offset amount for the associated clinical APC in which the drug or biological is utilized. The calculation of the "policy-packaged" drug and device APC offset amounts are described in more detail in section IV.A.2. of this final rule with comment period. It follows that the copayment for the nonpass-through payment portion (the otherwise applicable fee schedule amount that we would also offset from payment for the drug or biological if a payment offset applies) of the total OPPS payment for those drugs and biologicals would, therefore, be accounted for in the copayment for the associated clinical APC in which the drug or biological is used.

According to section 1833(t)(8)(E) of the Act, the amount of copayment associated with pass-through items is equal to the amount of copayment that would be applicable if the pass-through adjustment was not applied. Therefore, as we did in CY 2010, we proposed to continue to set the associated copayment amount for pass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals that would otherwise be packaged if the item did not have pass-through status to zero for CY 2011. The separate OPPS payment to a hospital for the pass-through diagnostic radiopharmaceutical, contrast agent, or implantable biological, after taking into account any applicable payment offset for the item due to the device or "policy-packaged" APC offset policy, is the item's pass-through payment, which is not subject to a copayment according to the statute. Therefore, we proposed to not publish a copayment amount for these items in Addenda A and B to the proposed rule.

As is our standard methodology, we annually review new permanent HCPCS codes and delete temporary HCPCS C-codes if an alternative permanent HCPCS code is available for purposes of OPPS billing and payment. We specifically review drugs with pass-through status for CY 2011 that will change from C-code to a permanent J-code for CY 2011. For our CY 2011 review, we have determined that HCPCS code J2426 (Injection, paliperidone palmitate, extended release, 1 mg) describes the product reported under HCPCS code C9255 (Injection, paliperidone palmitate, 1 mg); HCPCS code J7312 (Injection, dexamethasone intravitreal implant, 0.1 mg) describes the product reported under HCPCS code C9256 (Injection, dexamethasone intravitreal implant, 0.1 mg); HCPCS code J3095 (Injection, telavancin, 10 mg) describes the product reported under HCPCS code C9258 (Injection, telavancin, 10 mg); HCPCS code J9307 (Injection, pralatrexate, 1 mg) describes the product reported under HCPCS code C9259 (Injection, pralatrexate, 1 mg); HCPCS code J9302 (Injection, ofatumumab, 10 mg) describes the product reported under HCPCS code C9260 (Injection, ofatumumab, 10 mg); HCPCS code J3357 (Injection, ustekinumab, 1 mg) describes the product reported under HCPCS code C9261 (Injection, ustekinumab, 1 mg); HCPCS code J1290 (Injection, ecallantide, 1 mg) describes the product reported under HCPCS code C9263 (Injection, ecallantide, 1 mg); HCPCS code J3262 (Injection, tocilizumab, 1 mg) describes the product reported under HCPCS code C9264 (Injection, tocilizumab, 1 mg); HCPCS code J9315 (Injection, romidepsin, 1 mg) describes the product reported under HCPCS code C9265 (Injection, romidepsin, 1 mg); HCPCS code J0775 (Injection, collagenase clostridium histolyticum, 0.01 mg) describes the product reported under HCPCS code C9266 (Injection, collagenase clostridium histolyticum, 0.1 mg); HCPCS code J7184 (Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO) describes the product reported under HCPCS code C9267 (Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO); HCPCS code J7335 (Capsaicin 8% patch, per 10 square centimeters) describes the product reported under HCPCS code C9268 (Capsaicin, patch, 10cm2); HCPCS code J0597 (Injection, C–1 Esterase inhibitor (human), Berinert, 10 units) describes the product reported under HCPCS code C9269 (Injection, C–1 Esterase inhibitor (human), Berinert, 10 units); HCPCS code J3385 (Injection, velaglucerase alfa, 100 units) describes the product reported under HCPCS code C9271 (Injection, velaglucerase alfa, 100 units); and HCPCS code J8562

(Fludarabine phosphate, oral, 10 mg) describes the product reported under HCPCS code Q2025 (Fludarabine phosphate, oral, 1 mg).

Comment: Several commenters supported CMS' proposal to provide payment at ASP+6 percent for drugs, biologicals, contrast agents, and radiopharmaceuticals that are granted pass-through status. One commenter approved of the proposal to use the ASP methodology that would provide payment based on WAC if ASP information is not available, and payment at 95 percent of AWP if WAC information is not available. Some commenters requested that CMS provide an additional payment for radiopharmaceuticals that are granted pass-through status.

Response: As discussed above, the statutorily mandated pass-through payment for CY 2011, in general, equals the amount determined under section 1842(o) of the Act minus the portion of the APC payment that CMS determines is associated with the drug or biological. Therefore, the pass-through payment is determined by subtracting the otherwise applicable payment amount under the OPPS (determined to be ASP+5 percent for CY 2011) from the amount determined under section 1842(o) of the Act (ASP+6 percent).

For CY 2011, consistent with our CY 2010 payment policy for diagnostic and therapeutic radiopharmaceuticals, we proposed to provide payment for both diagnostic and therapeutic radiopharmaceuticals with pass-through status based on the ASP methodology. As stated above, the ASP methodology, as applied under the OPPS, uses several sources of data as a basis for payment, including the ASP, WAC if ASP is unavailable, and 95 percent of the radiopharmaceutical's most recent AWP if ASP and WAC are unavailable. For purposes of pass-through payment, we consider radiopharmaceuticals to be drugs under the OPPS. Therefore, if a diagnostic or therapeutic radiopharmaceutical receives pass-through status during CY 2011, we proposed to follow the standard ASP methodology to determine its pass-through payment rate under the OPPS. We have routinely provided a single payment for drugs, biologicals, and radiopharmaceuticals under the OPPS to account for the acquisition and pharmacy overhead costs, including compounding costs. We continue to believe that a single payment is appropriate for diagnostic radiopharmaceuticals with pass-through status in CY 2011 and that the payment rate of ASP+6 percent (or payment based on the ASP methodology) is appropriate to provide payment for both the radiopharmaceutical's acquisition cost and any associated nuclear medicine handling and compounding costs. We refer reader to section V.B.3.c. of this final rule with comment period for further discussion of payment for therapeutic radiopharmaceuticals based on ASP information submitted by manufacturers and the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/*.

Comment: Some commenters expressed concern that a radiopharmaceutical may receive pass-through payment for a period of possibly only 2 years. Several commenters recommended providing pass-through payment for approved radiopharmaceuticals for a full 3 year time period to allow hospitals time to incorporate new products into their chargemasters and billing practices.

Response: The statute specifically allows for pass-through payment for drugs and biologicals to be made for at least 2 years, but no more than 3 years. We believe this period of payment facilitates dissemination of these new products into clinical practice and for the collection of hospital claims data reflective of their costs for future OPPS ratesetting. Our longstanding practice has been to provide pass-through payment for a period of 2 to 3 years, with expiration of pass-through status proposed and finalized through the annual rulemaking process. Each year, when proposing to expire the pass-through status of certain drugs and biologicals, we examine our claims data for these products. We observe that hospitals typically have incorporated these products into their chargemasters based on the utilization and costs observed in our claims data. Under the existing pass-through policy, which has been generally supported by commenters, we begin pass-through payment on a quarterly basis that depends on when applications are submitted to us for consideration and we expire pass-through status only on an annual basis, so there is no way to ensure that all pass-through drugs and biologicals receive pass-through payment for a full 3 years, while also providing pass-through payment for no more than 3 years as the statute requires. Therefore, we will continue to provide drug and biologicals pass-through payment for at least 2 years, but no more than 3 years, as required by the statute.

There is currently one diagnostic radiopharmaceutical, described by HCPCS code A9582 (Iodine I–123 iobenguane, diagnostic, per study dose, up to 15 millicuries), that has been granted pass-through status at the time of issuance of this final rule with comment period. We proposed to continue pass-through status for this diagnostic radiopharmaceutical as it would not have received at least 2 years but not more than 3 years of pass-through payment by December 31, 2010. This is consistent with the OPPS provision that provides for at least 2 years but not more than 3 years of pass-through payment for drugs and biologicals that are approved for pass-through payments.

We provide an opportunity through the annual OPPS/ASC rulemaking cycle for public comment on those drugs and biologicals that are proposed for expiration of pass-through payment at the end of the next calendar year. We have often received public comments related to our proposed expiration of pass-through status for drugs and biologicals in the future. In this manner, we address specific concerns about the pass-through payment period for individual drugs, biologicals, and radiopharmaceuticals.

Comment: One commenter recommended that CMS monitor the cost and utilization data on HCPCS code A9583 (Injection, gadofosveset trisodium, 1 ml) on a quarterly basis throughout CY 2010 and CY 2011 to determine whether a third year of pass-through payment is necessary. The commenter noted that HCPCS code A9583, as a contrast agent and a "policy-packaged" item, would be packaged after its pass-through status ends.

Response: As stated above, section 1833(t)(6)(C)(i)(II) of the Act provides transitional pass-through payments for a drug or biological for at least 2 years, but not more than 3 years, beginning on the first date on which payment is made as hospital outpatient services under Medicare Part B. Under our current policy, supported by commenters, we begin pass-though payment on a quarterly basis that depends on when applications are submitted to us for consideration, and we expire pass-through status only on an annual basis through the rulemaking process. Accordingly, there is no way to ensure that all pass-through drugs and biologicals receive pass-through payment for a full 3 years, while also providing pass-through payment for no more than 3 years, as the statute requires. Although it is our standard practice to monitor and review the cost and utilization data of all drugs and biologicals, because of our policy to expire pass-through status only on an annual basis through rulemaking, we could not use this information to authorize a full third year of pass-

through payment for an individual drug or biological. Therefore, once pass-through status ends for the item described by HCPCS code A9583 (Injection, gadofosveset trisodium, 1 ml) after at least 2 years but not more than 3 years according to the statute, as a contrast agent, it will be packaged according to our policy described in section V.B.2.d. of this final rule with comment period. We are finalizing our proposal to continue pass-through status for the item described by HCPCS code A9583 for CY 2011.

Comment: Several commenters supported the CY 2011 proposal to continue to set the associated copayment amounts for pass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals that would otherwise be packaged if the product did not have pass-through status to zero. The commenters noted that this policy is consistent with statutory requirements and provides cost-saving benefits to beneficiaries.

Response: We appreciate the commenters' support of our proposal. As discussed in the CY 2011 OPPS/ASC proposed rule (75 FR 46259), we believe that, for drugs and biologicals that are "policy-packaged," the copayment for the nonpass-through payment portion of the total OPPS payment for this subset of drugs and biologicals is accounted for in the copayment for the associated clinical APC in which the drug or biological is used. According to section 1833 (t)(8)(E) of the Act, the amount of copayment associated with pass-through items is equal to the amount of copayment that would be applicable if the pass-through adjustment was not applied. Therefore, we believe that the amount should be zero for drugs and biologicals that are "policy-packaged," including diagnostic radiopharmaceuticals.

Comment: One commenter noted that CMS omitted 7 of the 31 pass-through drugs and biologicals proposed to continue on pass-through status for CY 2011 in Addendum B to the CY 2011 OPPS/ASC proposed rule. The commenter was concerned that the absence of these drugs and biologicals in Addendum B could cause hospitals or Medicare contractors to believe that the products are not paid for under the OPPS as pass-through drugs.

Response: Table 21 of the CY 2011 OPPS/ASC proposed rule (75 FR 46260) contained 31 drugs, biologicals, and radiopharmaceuticals that we proposed to continue on pass-through status for CY 2011. This table included drugs, biologicals, and radiopharmaceuticals approved for pass-through status for the July 2010 quarterly update. While the commenter did not specifically mention which codes were omitted from Addendum B to the proposed rule, we note that HCPCS codes C9264 (Injection, tocilizumab, 1 mg), C9265 (Injection, romidepsin, 1 mg), C9266 (Injection, collagenase clostridium histolyticum, 0.1 mg), C9267 (Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO), C9268 (Capsaicin, patch, 10cm2), C9367 (Skin substitute, Endoform Dermal Template, per square centimeter), all approved for pass-through status for the July 2010 quarterly update, and Q2025 (Fludarabine phosphate, oral, 1 mg) were not included in Addendum B of the proposed rule.

According to our current practice, we did not include pass-through payment rates for those drugs, biologicals, and radiopharmaceuticals that were newly approved for pass-through status for July 2010 in Addendum B to the CY 2011 OPPS/ASC proposed rule. It has been our longstanding practice to include only payment rates for pass-through drugs, biologicals, and radiopharmaceuticals in Addendum B to the proposed rule that have been approved for payment under the OPPS through the April quarterly update because of the difficulty of coordinating production of the Addendum B to the proposed rule concurrently with decisions about pass-through drugs and biologicals for the July quarterly update transmittal. Payment rates for all pass-through drugs, biologicals, and radiopharmaceuticals that are proposed and finalized to continue on pass-through status for a given calendar year are included in Addendum B to the final rule with comment period.

Additionally, pass-through payment for the product described by HCPCS code Q2025 (Fludarabine phosphate, oral, 1 mg) was included in Addendum B to the CY 2011 OPPS/ASC proposed rule under the now discontinued HCPCS code C9262 (Fludarabine phosphate, oral, 1 mg). Beginning in July 2010, HCPCS code C9262 was deleted and replaced with HCPCS code Q2025. For CY 2011, HCPCS code Q2025 is finalized as HCPCS code J8562 (Fludarabine phosphate oral, 10mg) and will continue under pass-through status for CY 2011.

We did not receive any public comments on our proposal to update pass-through payment rates on a quarterly basis on the CMS Website during CY 2011 if later quarter ASP submissions (or more recent WAC or AWP information, as applicable) indicate that adjustments to the payment rates for these pass-through drugs and biologicals are necessary.

After consideration of the public comments we received, we are finalizing our CY 2011 pass-through payment proposals, without modification. Specifically, we are providing pass-through payment in CY 2011 for those drugs, biologicals, and radiopharmaceuticals listed in Table 28 below. Payment for drugs, biologicals, and radiopharmaceuticals granted pass-through status will be made at the payment rate specified in section 1842(o) of the Act, that is, ASP+6 percent. For drugs and biologicals that are not diagnostic radiopharmaceuticals, contrast agents, or implantable biologicals, the pass-through payment amount is equal to the difference between payment for the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the drug or biological, which is payment at ASP+5 percent and the payment rate specified in section 1842(o) of the Act, ASP+6 percent or the Part B drug CAP rate as applicable. For contrast agents, diagnostic radiopharmaceuticals, and implantable biologicals, the pass-through payment is equal to the difference between the policy-packaged offset amount associated with an APC (discussed in V.A.4. of this final rule with comment period) and the payment rate specified in section 1842(o) of the Act of ASP+6 percent. If ASP data are not available, payment for these pass-through drugs and biologicals will be based on the standard OPPS ASP methodology, that is, payment at WAC+6 percent if ASP data are not available, and payment at 95 percent of the pass-through drug's, biological's, or radiopharmaceutical's most recent AWP if WAC information is not available. We will update pass-through payment rates on a quarterly basis on the CMS website during CY 2011 if later ASP submissions (or more recent WAC or AWP information, as applicable) indicate that adjustments to the payment rates for pass-through drugs and biologicals are necessary. We will set the associated copayment amount for pass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals approved for pass-through as a biological prior to January 1, 2010 that would otherwise be packaged if the item did not have pass-through status to zero. The separate OPPS payment to a hospital for pass-through diagnostic radiopharmaceuticals, contrast agents, or implantable biologicals, after taking into account any applicable payment offset for the item due to the device or

"policy packaged" APC offset policy, is the item's pass-through payment, which is not subject to a copayment, according to the statute. Finally, if a drug or biological that has been granted pass-through status for CY 2011 becomes covered under the Part B drug CAP if the program is reinstituted, we will provide pass-through payment at the Part B drug CAP rate and make the appropriate adjustment to the payment rates for the drugs and biologicals on a quarterly basis as appropriate.

The 42 drugs and biologicals that are continuing on pass-through status for CY 2011 or that have been granted pass-through status as of January 2011 are displayed in Table 28 below.

TABLE 28—DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2011

CY 2010 HCPCS code	CY 2011 HCPCS code	CY 2011 long descriptor	Final CY 2011 SI	Final CY 2011 APC
A9582	A9582	Iodine I–123 iobenguane, diagnostic, per study dose, up to 15 millicuries	G	9247
A9583	A9583	Injection, gadofosveset trisodium, 1 ml	G	1299
C9250	C9250	Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2 ml	G	9250
C9255	J2426	Injection, paliperidone palmitate, extended release, 1 mg	G	9255
C9256	J7312	Injection, dexamethasone intravitreal implant, 0.1 mg	G	9256
C9258	J3095	Injection, telavancin, 10 mg	G	9258
C9259	J9307	Injection, pralatrexate, 1 mg	G	9259
C9260	J9302	Injection, ofatumumab, 10 mg	G	9260
C9261	J3357	Injection, ustekinumab, 1 mg	G	9261
C9263	J1290	Injection, ecallantide, 1 mg	G	9263
C9264	J3262	Injection, tocilizumab, 1 mg	G	9624
C9265	J9315	Injection, romidepsin, 1 mg	G	9625
C9266	J0775	Injection, collagenase clostridium histolyticum, 0.01 mg	G	1340
C9267	J7184	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO.	G	9267
C9268	J7335	Capsaicin 8% patch, per 10 square centimeters	G	9268
C9269	J0597	Injection, C–1 Esterase inhibitor (human), Berinert, 10 units	G	9269
C9270	C9270	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (*e.g.* liquid), 500 mg.	G	9270
C9271	J3385	Injection, velaglucerase alfa, 100 units	G	9271
C9272	C9272	Injection, denosumab, 1 mg	G	9272
C9273	C9273	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAPGM–CSF in 250 mL of Lactated Ringer's, including leukapheresis and all other preparatory procedures, per infusion.	G	9273
	C9274	Crotalidae polyvalent immune fab (ovine), 1 vial	G	9274
	C9275	Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose	G	9275
	C9276	Injection, cabazitaxel, 1 mg	G	9276
	C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	G	9277
	C9278	Injection, incobotulinumtoxin A, 1 unit	G	9278
	C9279	Injection, ibuprofen, 100 mg	G	9279
C9360	C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters.	G	9360
C9361	C9361	Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 centimeter length.	G	9361
C9362	C9362	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc.	G	9362
C9363	C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter.	G	9363
C9364	C9364	Porcine implant, Permacol, per square centimeter	G	9364
C9367	C9367	Skin substitute, Endoform Dermal Template, per square centimeter	G	9367
J0598	J0598	Injection, C1 esterase inhibitor (human), 10 units	G	9251
J0641	J0641	Injection, levoleucovorin calcium, 0.5 mg	G	1236
J0718	J0718	Injection, certolizumab pegol, 1 mg	G	9249
J1680	J1680	Injection, human fibrinogen concentrate, 100 mg	G	1290
J2562	J2562	Injection, plerixafor, 1 mg	G	9252
J8705	J8705	Topotecan, oral, 0.25 mg	G	1238
J9155	J9155	Injection, degarelix, 1 mg	G	1296
J9328	J9328	Injection, temozolomide, 1 mg	G	9253
Q0138	Q0138	Injection, Ferumoxytol, for treatment of iron deficiency anemia, 1 mg	G	1297
Q2025	J8562	Fludarabine phosphate, oral, 10 mg	G	1339

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

a. Background

Prior to CY 2008, diagnostic radiopharmaceuticals and contrast agents were paid separately under the OPPS if their mean per day costs were greater than the applicable year's drug packaging threshold. In CY 2008 (72 FR 66768), we began a policy of packaging payment for all nonpass-through diagnostic radiopharmaceuticals and contrast agents as ancillary and supportive items and services into their associated nuclear medicine procedures. Therefore, beginning in CY 2008, nonpass-through diagnostic radiopharmaceuticals and contrast agents were not subject to the annual OPPS drug packaging threshold to determine their packaged or separately payable payment status, and instead all nonpass-through diagnostic radiopharmaceuticals and contrast agents were packaged as a matter of policy. In the CY 2011 OPPS/ASC proposed rule (75 FR 46261), for CY 2011, we proposed to continue to package payment for all nonpass-through diagnostic radiopharmaceuticals and contrast agents, as discussed in section V.B.2.d. of the proposed rule and this final rule with comment period.

b. Payment Offset Policy for Diagnostic Radiopharmaceuticals

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

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

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

In order to ensure that the OPPS is making appropriate and equitable payments under such circumstances and that a hospital can comply with the required radiolabeled product edits, in the CY 2011 OPPS/ASC proposed rule (75 FR 46261 through 46262), we proposed for CY 2011 to instruct hospitals to report the "FB" modifier on the line with the procedure code for the nuclear medicine scan in the APCs listed in Table 22 of the proposed rule in which the no cost/full credit diagnostic radiopharmaceutical is used. Modifier "FB" is defined as an "Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)." Although this modifier is specific to devices, it captures the concept of the hospital receiving a key component of the service without cost. In cases in which the diagnostic radiopharmaceutical is furnished without cost or with full credit, we proposed to instruct the hospital to report a token charge of less than $1.01. We refer readers to the CY 2008 OPPS/ASC final rule with comment period for more background information on the "FB" modifier payment adjustment policies (72 FR 66743 through 66749). We proposed that when a hospital bills with an "FB" modifier with the nuclear medicine

scan, the payment amount for procedures in the APCs listed in Table 22 of the proposed rule would be reduced by the full "policy-packaged" offset amount appropriate for diagnostic radiopharmaceuticals.

As discussed in the CY 2009 OPPS/ASC final rule with comment period, the "policy packaged" offset amount that we calculate estimates the portion of each APC payment rate that could reasonably be attributed to the cost of predecessor diagnostic radiopharmaceuticals when considering a new diagnostic radiopharmaceutical for pass through payment (73 FR 68638 through 68641). As in our offset policy, discussed below, we believe it is appropriate to remove the "policy packaged" offset amount from payment for a nuclear medicine scan with a diagnostic radiopharmaceutical received at no cost or full credit which is billed using one of the APCs appearing in Table 29 below, because it represents the portion of the APC payment attributable to diagnostic radiopharmaceuticals used in the performance of a nuclear medicine scan. Using the "FB" modifier with radiolabeled products will allow the hospital to bill accurately for a diagnostic radiopharmaceutical received free of charge and will allow the hospital to comply with the radiolabeled product edits to ensure appropriate payment.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46262), we did not propose to recognize modifier "FC," which is defined as "Partial credit received for replaced device," because we were unsure of the circumstances in which hospitals would receive a diagnostic radiopharmaceutical at reduced cost to replace a previously provided diagnostic radiopharmaceutical. We note that most of the questions that we have received pertain to coding of free sample or trial diagnostic radiopharmaceuticals received free of charge. We invited public comment on when a diagnostic radiopharmaceutical is provided for a significantly reduced price and whether the "FC" modifier is appropriate for radiolabeled products.

Comment: Several commenters supported CMS' proposal to instruct hospitals to report modifier "FB" on the line with the procedure code for the nuclear medicine scan when a diagnostic radiopharmaceutical is received free of charge or with full credit. The commenters stated that implementing this proposal would lead to more accurate billing and would prevent inappropriate payment for diagnostic radiopharmaceuticals received free of charge or with full credit. One commenter opposed CMS' proposal to instruct hospitals to report modifier "FB" on the line with the procedure code for the nuclear medicine scan, stating that a modifier for radiopharmaceuticals is unnecessary. The commenter further stated that radiopharmaceuticals cannot be compared to devices because of their pricing differences, since devices generally constitute a significant portion of the total procedure charges and radiopharmaceuticals only make up a small portion of the charge for radiology services. In addition, the commenter stated that the reasons for free or partial charge devices are generally manufacturer-related defects, such as recalls and other failures during the warranty period, and that radiopharmaceuticals are treated differently, in that when they are recalled, hospitals do not continue to stock them and, therefore, they would not be administered or billed.

Response: We appreciate commenter's support for our proposal. As stated in the CY 2011 OPPS/ASC proposed rule (75 FR 46261 through 46262), instructing hospitals to use the "FB" modifier on the line with the procedure code for the nuclear medicine scan would allow the hospital to bill accurately for a diagnostic radiopharmaceutical received free of charge and will allow the hospital to comply with the radiolabeled product edits to ensure appropriate payment.

We have received questions from hospitals that have asked how to properly bill for diagnostic radiopharmaceuticals obtained free of charge. We believe that there is a need for hospitals to properly account for diagnostic radiopharmaceuticals received free of charge. Therefore, we disagree with the commenter's assertion that there is no need for a modifier for diagnostic radiopharmaceuticals received with no cost or free of charge. In addition, we do not find the argument compelling that a modifier for radiopharmaceuticals is not necessary because the cost of a radiopharmaceutical is lower than the cost of a device and because the cost of a radiopharmaceutical constitutes a lower percentage of the total charge for the associated primary procedure. We believe the commenter is making a marginal cost argument, that coding the "FB" modifier for devices makes sense because the recouped costs to the Medicare program could be significant depending on the device. While we agree that the device portion of a device-dependent APC subject to the "FB" and "FC" policy will have a higher absolute dollar value than the policy-packaged portion of a nuclear medicine APC, we do not believe this should preclude a hospital from being able to bill and be paid correctly for a nuclear medicine scan when provided with a diagnostic radiopharmaceutical that the hospital received free of charge or at no cost. We have consistently emphasized the importance of correct coding for all drugs, biologicals, and radiopharmaceuticals administered in the, regardless of the cost, in our instructions to hospitals. Establishing the "FB" modifier to correctly account for diagnostic radiopharmaceuticals received free of charge allows for the diagnostic radiopharmaceutical to be reported and coded correctly on the same claim as the nuclear medicine scan, therefore fulfilling the required radiolabeled product edits. It also is possible that volume for nuclear medicine scans may result in more total aggregated savings on free-of-charge radiopharmaceuticals than devices, but our primary goal in instituting the "FB" modifiers for radiopharmaceuticals received free-of-charge or at no cost is for accurate billing and payment. With regard to the comment that using the "FB" modifier with diagnostic radiopharmaceuticals is not necessary because hospitals would choose not to stock any radiopharmaceuticals after they are recalled or identified as having defects, we note that most of the questions that we have received pertain to coding of free sample or trial diagnostic radiopharmaceuticals received free of charge.

Comment: One commenter supported CMS' proposal to require hospitals to report the "FB" modifier but suggested that CMS revise the description to read "Item provided without cost to provider, supplier, or practitioner, or full credit received for replaced device *or radiopharmaceutical* (examples, but not limited to, covered under warranty, replaced due to defect, free sample)" (emphasis added).

Response: We appreciate the commenter's support. However, we do not establish HCPCS code modifiers through rulemaking, including this OPPS final rule with comment period. The CMS HCPCS Workgroup develops, revises, and deletes Level II HCPCS codes and Level II HCPCS modifiers. The "FB" modifier is a Level II HCPCS modifier. We will consider taking this request to the CMS HCPCS Workgroup for their consideration.

Comment: One commenter suggested that CMS instruct hospitals to use the "FB" modifier when hospitals incur no cost for the diagnostic radiopharmaceutical when a diagnostic radiopharmaceutical is administered in

a nonhospital location and then the nuclear medicine scan is performed at another facility.

Response: We do not believe that the use of the "FB" modifier should be extended to the situation where a nonhospital location administers the diagnostic radiopharmaceutical under arrangement with a hospital administering the nuclear medicine scan because the "FB" modifier is defined as "Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)". The hospital administering the scan didn't receive the item at no cost or full credit. We believe it would be rare for a nonhospital location, such as a physician office, to voluntarily administer a diagnostic radiopharmaceutical and then refer the patient to the hospital for the nuclear medicine scan as a hospital outpatient. In that circumstance, the physician's office would already have billed Medicare for the radiopharmaceutical. The hospital would be unable to bill Medicare for that scan because our radiolabeled product edits require a hospital always to bill a nuclear medicine scan with a diagnostic radiopharmaceutical, and in this circumstance, the hospital did not administer a diagnostic radiopharmaceutical. We do not believe it is likely that a facility other than the hospital administering the nuclear medicine scan would administer a diagnostic radiopharmaceutical without conducting the nuclear medicine scan themselves unless the facility had an arrangement with a hospital to provide the diagnostic radiopharmaceutical for the hospital. We will monitor our correspondence with hospitals about our radiolabeled product edits to see if this situation is more common than we believe. We note that we have addressed the more common scenario of an inpatient receiving a diagnostic radiopharmaceutical in the inpatient setting, and having a follow-up nuclear medicine scan the next day as a hospital outpatient after discharge by creating HCPCS code C9898 (Input stay radiolabeled item) for hospitals to report in place of a radiopharmaceutical.

We believe it is more likely that a nonhospital location, such as an independent testing facility (IDTF), would provide a diagnostic radiopharmaceutical under arrangement with a hospital. In this circumstance, it would be inappropriate to remove the "policy-packaged" offset amount from payment for the nuclear medicine scan because the hospital location would incur the cost of the radiopharmaceutical by paying the nonhospital location for furnishing the radiopharmaceutical to the hospital's registered outpatient under arrangement. We have given instructions in CMS Transmittal 2050, Change Request 7117, issued September 17, 2010, addressing when a radiolabeled product is administered in one hospital and the nuclear medicine scan is subsequently performed at another hospital. Where a hospital or other entity (a nonhospital location in this example) administers a diagnostic radiopharmaceutical product for a different hospital providing the nuclear medicine scan, the first hospital or other entity may enter into an arrangement under section 1861(w)(1) of the Act, and as discussed in 42 CFR 410.28(a)(1) and defined in 42 CFR 409.3, where the second hospital that administers the nuclear medicine scan both bills Medicare for the administration of the nuclear medicine scan with diagnostic radiopharmaceutical and pays the first hospital or other entity that administers the diagnostic radiopharmaceutical some amount for administration of the diagnostic radiopharmaceutical.

Comment: A few commenters supported CMS' decision not to propose to require hospitals to use the "FC" modifier in cases where a hospital receives a diagnostic radiopharmaceutical at reduced cost to replace a previously provided diagnostic radiopharmaceutical. The commenters stated that this type of partial pricing is not common in the nuclear medicine field, and hospitals already have ways to set two different charges for the same radiopharmaceutical to account for reduced costs.

Response: We appreciate the commenters' response.

After consideration of the public comments we received, we are finalizing our proposal to instruct hospitals to report the "FB" modifier on the line with the procedure code for the nuclear medicine scan in the APCs listed in Table 29 in which the no cost/full credit diagnostic radiopharmaceutical is used for CY 2011. We are also finalizing our proposal to instruct hospitals to report a token charge of less than $1.01 in cases in which the diagnostic radiopharmaceutical is furnished without cost or with full credit. We did not propose to finalize a policy to require hospitals to add an "FC" modifier to the procedure code for the nuclear medicine scan to account for diagnostic radiopharmaceuticals that are received at reduced cost.

Comment: One commenter supported the continuation of the pass-through diagnostic radiopharmaceutical offset policy for CY 2011.

Response: We appreciate the commenter's support. We continue to believe that a diagnostic radiopharmaceutical offset policy is necessary in order to ensure that duplicate payment is not made for diagnostic radiopharmaceuticals with pass-through status. We believe it is appropriate to remove the radiopharmaceutical payment amount that is already packaged into the payment for the associated nuclear medicine procedure when we provide pass-through payment for a diagnostic radiopharmaceutical with pass-through status.

Comment: One commenter requested that CMS post all data used to calculate the offset amounts and stated that, without these amounts, the public cannot make comments on the accuracy and appropriateness of CMS' calculation of radiopharmaceutical costs packaged into the nuclear medicine APC or the corresponding offset amounts for pass-through radiopharmaceuticals. One commenter also requested that CMS post the offset files at the same time that the OPPS/ASC proposed rules are issued. The commenter stated that without these files, they are unable to predict or comment prior to final offsets being implemented. These commenters further stated that adequate pricing of all radiopharmaceuticals is important as new technologies are being developed and utilized.

Response: The exact data used to calculate all of the proposed and final payment rates, including the associated offset amounts, for the CY 2011 OPPS are available for purchase under a CMS data use agreement through the CMS Web site at: *http://www.cms.gov/hospitalOutpatientPPS.* This Web site includes information about purchasing the "OPPS Limited Data Set," which now includes the additional variables previously available only in the OPPS Identifiable Data Set, including ICD–9–CMS diagnosis codes and revenue code payment amounts. We refer readers to section II.A.2. of this final rule with comment period for more information on data development and the calculation of median costs. We note that our description of the payment offset policy calculation for diagnostic radiopharmaceuticals is referenced above. We typically have not posted the offset amounts by APC until publication of the final rule because we assign services to APCs based on our estimate

of their full resource cost, including, but not limited to, packaged diagnostic radiopharmaceuticals. The offset amount is the portion of each APC payment rate that could reasonably be attributed to the cost of predecessor diagnostic radiopharmaceuticals when considering a new diagnostic radiopharmaceutical for pass-through payment and has no bearing on APC assignment. We will consider making preliminary offset amounts available for the CY 2011 proposed rule. With regard to pricing for new radiopharmaceuticals and technologies, we note that the purpose of the pass-through provision, with specific payment at ASP+6 using the ASP methodology, is to make it easier for hospitals to try these new products.

Comment: One commenter asked about the proper billing of diagnostic radiopharmaceuticals and nuclear medicine scans when the diagnostic radiopharmaceutical is administered in the HOPD and the nuclear medicine scan is subsequently performed in the inpatient department of a hospital.

Response: If a patient received a diagnostic radiopharmaceutical as an outpatient and was then admitted as an inpatient before receiving a nuclear medicine scan, payment to the hospital for this patient would be paid using a Medicare Severity Diagnosis-Related Group (MS–DRG) under the IPPS and would include the cost of both the nuclear medicine scan and the diagnostic radiopharmaceutical because it is our long standing policy to bundle billing of outpatient diagnostic services into payment for the inpatient admission (42 CFR 412.2(c)(5)(ii)).

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to apply the diagnostic radiopharmaceutical offset policy to payment for pass-through diagnostic radiopharmaceuticals, as described above. Table 29 below displays the APCs to which nuclear medicine procedures are assigned in CY 2011 and for which we expect that an APC offset could be applicable in the case of diagnostic radiopharmaceuticals with pass-through status.

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

TABLE 29—APCs TO WHICH NUCLEAR MEDICINE PROCEDURES ARE ASSIGNED FOR CY 2011

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

c. Payment Offset Policy for Contrast Agents

As described above, section 1833(t)(6)(D)(i) of the Act specifies that the transitional pass-through payment amount for pass-through drugs and biologicals is the difference between the amount paid under section 1842(o) of the Act (or the Part B drug CAP rate) and the otherwise applicable OPD fee schedule amount. There are currently two contrast agents with pass-through status under the OPPS: HCPCS code A9583 (Injection, gadoxetate disodium, per ml) and HCPCS code C9275 (Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose). HCPCS code A9583 was granted pass-through status beginning January 1, 2010, and will continue with pass-through status in CY 2011, and HCPCS code C9275 was granted pass-through status beginning January 1, 2011, and will continue with pass-through status in CY 2011. As described earlier in section V.A.3. of this final rule with comment period, new pass-through contrast agents will be paid at ASP+6 percent, while those without ASP information will be paid at WAC+6 percent or, if WAC is not available, payment will be based on 95 percent of the product's most recently published AWP.

We believe that a payment offset is necessary in order to provide an appropriate transitional pass-through payment for contrast agents, because all of these items are packaged when they do not have pass-through status. In accordance with our standard offset

methodology, in the CY 2011 OPPS/ASC proposed rule (75 FR 46263), we proposed for CY 2011 to deduct from the payment for pass-through contrast agents an amount that reflects the portion of the APC payment associated with predecessor contrast agents, in order to ensure no duplicate contrast agent payment is made.

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

We did not receive any public comments on our proposal to deduct, from the payment for pass-through contrast agents, an amount that reflects the portion of the APC payment associated with predecessor contrast agents in order to ensure no duplicate contrast agent payment is made. We are finalizing the proposed CY 2011 pass-through contrast agent offset policy to specify the procedural APCs to which offsets for pass-through contrast agents would apply. In addition, as proposed, for this final rule with comment period, we have identified in Table 30 below procedural APCs for which we expect a contrast agent offset could be applicable in the case of a pass-through contrast agent as any procedural APC with a "policy-packaged" drug amount greater than $20 that is not a nuclear medicine APC identified in Table 27 above. The methodology used to determine a threshold cost for application of a contrast agent offset policy is described in detail in the CY 2010 OPPS/ASC final rule with comment period (70 FR 60483 through 60484). We are finalizing this methodology for CY 2011 to continue to recognize that when a contrast agent with pass-through status is billed with any procedural APC listed in Table 30, a specific offset based on the procedural APC would be applied to payment for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

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

TABLE 30—APCS TO WHICH A CONTRAST AGENT OFFSET MAY BE APPLICABLE FOR CY 2011

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

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

1. Background

Under the CY 2010 OPPS, we currently pay for drugs, biologicals, and radiopharmaceuticals that do not have pass-through status in one of two ways: As a packaged payment into the payment for the associated service; or as a separate payment (individual APCs). We explained in the April 7, 2000 OPPS final rule with comment period (65 FR 18450) that we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment for packaged items and supplies, and hospitals may not bill beneficiaries separately for any packaged items and supplies whose costs are recognized and paid within the national OPPS payment rate for the associated procedure or service. (Transmittal A–01–133, issued on November 20, 2001, explains, in greater detail, the rules regarding separate payment for packaged services.)

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

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

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

a. Background

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

Following the CY 2007 methodology, for CY 2011, we used updated four quarter moving average PPI levels to trend the $50 threshold forward from the third quarter of CY 2005 to the third quarter of CY 2011 and again rounded the resulting dollar amount ($70.64) to the nearest $5 increment, which yielded a figure of $70. In performing this calculation, we used the most recent forecast of the quarterly index levels for the PPI for Pharmaceuticals for Human Use (Prescription) (Bureau of Labor Statistics (BLS) series code WPUSI07003) from CMS' Office of the Actuary (OACT). We note that we are not making a change to the PPI that is used to calculate the threshold for CY 2011; however, there was a recent change to the BLS naming convention for this series. We refer to this series generally as the PPI for Prescription Drugs below. We chose this PPI as it reflects price changes associated with the average mix of all pharmaceuticals in the overall economy. In addition, we chose this price series because it is publicly available and regularly published improving public access and transparency. Forecasts of the PPI for Prescription Drugs are developed by IHS Global Insight, Inc., a nationally recognized economic and financial forecasting firm. As actual inflation for past quarters replaced forecasted amounts, the PPI estimates for prior quarters have been revised (compared with those used in the CY 2007 OPPS/ASC final rule with comment period) and have been incorporated into our calculation. Based on the calculations described above, in the CY 2011 OPPS/ASC proposed rule (75 FR 46265), we proposed a packaging threshold for CY 2011 of $70. (For a more detailed discussion of the OPPS drug packaging threshold and the use of the PPI for Prescription Drugs, we refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68085 through 68086).)

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

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

To calculate the CY 2011 proposed rule per day costs, we used an estimated

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

As is our standard methodology, for CY 2011, we proposed to use payment rates based on the ASP data from the fourth quarter of CY 2009 for budget neutrality estimates, packaging determinations, impact analyses, and completion of Addenda A and B to the proposed rule, because these were the most recent data available for use at the time of development of the proposed rule. These data were also the basis for drug payments in the physician's office setting, effective April 1, 2010. For items that did not have an ASP-based payment rate, such as some therapeutic radiopharmaceuticals, we used their mean unit cost derived from the CY 2009 hospital claims data to determine their per day cost. We proposed to package items with a per day cost less than or equal to $70 and identified items with a per day cost greater than $70 as separately payable. Consistent with our past practice, we crosswalked historical OPPS claims data from the CY 2009 HCPCS codes that were reported to the CY 2010 HCPCS codes that we displayed in Addendum B to the proposed rule for payment in CY 2011.

Comment: The majority of commenters objected to the proposed increase in the OPPS packaging threshold to $70 for CY 2011. A few commenters recommended that CMS consider either eliminating the drug packaging threshold and providing separate payment for all drugs with HCPCS codes or freezing the packaging threshold at $65 for CY 2011. One commenter, in particular, suggested that CMS freeze the packaging threshold for at least one year. Some commenters objected to the use of a packaging threshold under the OPPS when one is not used for physician's office payment. These commenters expressed concern that the packaging threshold may impede beneficiary access to lower-cost packaged drugs in the HOPD setting. A few commenters suggested that CMS limit increases in the packaging threshold amount to the market basket update for the year. One commenter also recommended that CMS not round up the threshold amount to the nearest $5 increment and instead defer increases in the threshold until changes in prices exceed $5.

Some commenters believed that eliminating the packaging threshold and paying separately for all drugs in the HOPD setting would allow a more accurate calculation of the separately payable payment amount for drugs (otherwise referred to as the ASP+X calculation).

Response: As discussed in detail in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66757 through 66758), the CY 2009 OPPS/ASC final rule with comment period (73 FR 68643), and the CY 2010 OPPS/ASC final rule with comment period (74 FR 60485 through 60487), we continue to believe that unpackaging payment for all drugs, biologicals and radiopharmaceuticals is inconsistent with the concept of a prospective payment system and that such a change could create an additional reporting burden for hospitals. The OPPS and the MPFS that applies to physician's office services are fundamentally different payment systems with essential differences in their payment policies and structures. Specifically, the OPPS is a prospective payment system, based on the concept of payment for groups of services that share clinical and resource characteristics. Payment is made under the OPPS according to prospectively established payment rates that are related to the relative costs of hospital resources for services. The MPFS is a fee schedule based on the relative value of each individual component of services. Under the MPFS approach, separate payment is made for each drug provided in the physician's office, but the OPPS packages payment for certain drugs into the associated procedure payment for the APC group. Given the fundamental difference between the MPFS payment mechanism and the OPPS payment mechanism, differences in the degrees of packaged payment and separate payment between these two systems are to be expected.

In general, we do not believe that our packaging methodology under the OPPS results in limited beneficiary access to drugs because packaging is a fundamental component of a prospective payment system that account for the cost of certain items and services in larger payment bundles, recognizing that some clinical cases may be more costly and others less costly, but that, on average, OPPS payment is appropriate for the services provided. The growing utilization associated with packaged drugs and biologicals in our claims data suggest Medicare beneficiaries have sufficient access to these items.

We note that, in CYs 2005 and 2006, the statutorily mandated drug packaging threshold was set at $50, and we continue to believe that it is appropriate to continue a modest drug packaging threshold for the CY 2011 OPPS for the reasons set forth below. As stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68086), we believe that packaging certain items is a fundamental component of a prospective payment system, that packaging these items does not lead to beneficiary access issues and does not create a problematic site of service differential, that the packaging threshold is reasonable based on the initial establishment in law of a $50 threshold for the CY 2005 OPPS, that updating the $50 threshold is consistent with industry and government practices, and that the PPI for Prescription Drugs is an appropriate mechanism to gauge Part B drug inflation. Therefore, because of our continued belief that packaging is a fundamental component of a prospective payment system that continues to provide important flexibility and efficiency in the delivery of high quality hospital outpatient services, we are not adopting the commenters' recommendations to pay separately for all drugs, biologicals, and radiopharmaceuticals for CY 2011 or to eliminate or to freeze the packaging threshold at $65.

We disagree with the commenters who suggested that CMS should limit increases in the outpatient drug packaging threshold amount to the market basket update for the year. As stated above, we continue to believe that updating the $50 threshold is consistent with industry and government practices and that the PPI for Prescription Drugs is an appropriate mechanism to gauge Part B drug inflation. As we stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68085), we believe that the PPI for Prescription Drugs reflects price changes at the wholesale or manufacturer stage. Because OPPS payment rates for drugs and biologicals are generally based on the ASP data that are reported by their manufacturers, we believe that the PPI for Prescription Drugs is an appropriate price index to use to update the packaging threshold for CY 2007 and beyond.

We note that the market basket update contains numerous price proxies, including but not limited to proxies for wages and salaries, utilities, and nonlabor-related expenses, that are not related to price increases for prescription drugs. Therefore, we

believe that the market basket as a whole is not an appropriate mechanism for determining the outpatient drug packaging threshold amount. Within the calculation of the market basket update, we use the PPI for Prescription Drugs specifically to measure the price growth for prescription drugs but price changes for prescription drugs are only one component of price changes for the numerous items and services hospital purchase. Additionally, we disagree with the commenters' suggestion that we not round up the packaging threshold to the nearest $5 increment and, instead, defer any increases in the threshold until changes in prices exceed $5. We note that we equally round up or round down to the nearest $5 increment, and we continue to believe that rounding to the nearest $5 increment is appropriate when determining the drug packaging threshold.

Finally, we believe that our continued application of the methodology initially adopted in CY 2007 to update the drug packaging threshold does not inhibit our ability to pay accurately for drugs and biologicals. We have made several refinements to the ASP+X drug payment methodology under the OPPS for nonpass-through drugs and biologicals over the past several years to improve its accuracy. During that time, we have continued to implement our established methodology for annually updating the drug packaging threshold. For CY 2010, we finalized an overhead adjustment methodology for determining payment for separately payable drugs without pass-through status while we have continued to consistently apply the methodology described above to update the drug packaging threshold.

For purposes of this final rule with comment period, we again followed the CY 2007 methodology for CY 2011 and used updated four quarter moving average PPI index levels to trend the $50 threshold forward from the third quarter of CY 2005 to the third quarter of CY 2011 and again rounded the resulting dollar amount ($68.57) to the nearest $5 increment, which yielded a figure of $70. In performing this calculation, we used the most recent forecast of the quarterly PPI index levels from CMS' OACT.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to continue using the established methodology for annually updating the OPPS packaging threshold for drugs and biologicals by the PPI for Prescription Drugs. The final CY 2011 drug packaging threshold is $70, calculated according to the threshold update methodology that we have applied since CY 2007.

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

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

- HCPCS codes for drugs and nonimplantable biologicals that were paid separately in CY 2010 and that were proposed for separate payment in CY 2011, and then have per day costs equal to or less than $70, based on the updated ASPs and hospital claims data used for this CY 2011 final rule with comment period, will continue to receive separate payment in CY 2011.
- HCPCS codes for drugs and nonimplantable biologicals that were packaged in CY 2010 and that were proposed for separate payment in CY 2011, and then have per day costs equal to or less than $70, based on the updated ASPs and hospital claims data used for this CY 2011 final rule with comment period, will remain packaged in CY 2011.
- HCPCS codes for drugs and nonimplantable biologicals for which we proposed packaged payment in CY 2011 but then have per day costs greater than $70, based on the updated ASPs and hospital claims data used for this CY 2011 final rule with comment period, will receive separate payment in CY 2011.

We did not receive any public comments on our proposal to apply the established policies initially adopted for the CY 2005 OPPS (69 FR 65780) in order to more equitably pay for those drugs whose median cost fluctuates relative to the CY 2011 OPPS drug packaging threshold and the drug's payment status (packaged or separately payable) in CY 2010. Therefore, we are finalizing our proposal, without modification, for CY 2011.

We note that HCPCS codes J0945 (injection, brompheniramine maleate, per 10 mg), J2320 (injection, nandrolone decanoate, up to 50 mg), and J2724 (Injection, protein c concentrate, intravenous, human, 10 iu) were paid separately for CY 2010 and were proposed for separate payment in CY 2011 and had final per day costs of less than the $70 drug packaging threshold, based on updated ASPs and the CY 2009 hospital claims data available for this CY 2011 final rule with comment period. Therefore HCPCS codes J0945,

J2320, and J2724 will continue to be paid separately in CY 2011 according to the established methodology set forth above.

In addition, we proposed to provide separate payment for HCPCS code J1835 (injection, itraconazole, 50 mg) in CY 2011, although its payment was packaged in CY 2010. Using updated ASPs and the CY 2009 hospital claims data available for this final rule with comment period, HCPCS code J1835 now has a per day cost of less than $70. In accordance with our established policy for such cases, for CY 2011 we will package payment for HCPCS code J1835.

Finally, we proposed to package HCPCS codes J0348 (Injection, anidulafungin, 1 mg), J2510 (injection, penicillin g procaine, aqueous, up to 600,000 units), J2700 (injection, oxacillin sodium, up to 250 mga), and J2805 (Injection, sincalide, 5 micrograms) for CY 2011. Using updated ASPs and the CY 2009 hospital claims data available for this final rule with comment period, HCPCS codes J0348, J2510, J2700, and J2805 now have per day costs greater than $70. In accordance with our established policy for such cases, for CY 2011 we will pay for HCPCS codes J0348, J2510, J2700, and J2805 separately.

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60485 through 60489), we implemented a policy to treat oral and injectable forms of 5–HT3 antiemetics comparable to all other threshold packaged drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals under our standard packaging methodology of packaging drugs with a per day cost less than $70. In the CY 2011 OPPS/ASC proposed rule (75 FR 46266), we proposed for CY 2011 to continue our policy of not exempting these 5–HT3 antiemetic products from our standard packaging methodology and to package payment for all of the 5–HT3 antiemetics except palonosetron hydrochloride, consistent with their estimated per day costs from the CY 2009 claims data.

Comment: The majority of commenters opposed the proposal to continue the CY 2010 policy of no longer exempting the oral and injectable forms of 5–HT3 antiemetics from the packaging threshold, thereby packaging all but one 5–HT3 antiemetic. Many commenters requested that CMS exempt all 5–HT3 antiemetics from the packaging methodology in order to preserve access to these products.

Response: We continue to believe that use of these antiemetics is an integral part of an anticancer treatment regimen and that OPPS claims data demonstrate their increasingly common hospital outpatient utilization. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60488), we no longer believe that a specific exemption to our standard drug payment methodology is necessary to ensure access to the most appropriate antiemetic products for Medicare beneficiaries. We continue to believe that our analysis conducted in the CY 2010 OPPS/ASC proposed rule on 5–HT3 antiemetics (74 FR 35320), along with the historical stability in prescribing patterns for these products and the availability of generic alternatives for several of these products, allows us to continue our policy of specifically not exempting these products from the OPPS drug packaging threshold. Therefore, we are finalizing our proposal of not exempting 5–HT3 antiemetic products from our standard packaging methodology and to packaged payment for all of the 5–HT3 antiemetics consistent with their per day costs from the CY 2009 claims data. Under this methodology, palonosetron hydrochloride will receive separate payment for CY 2011. We expect that packaging will encourage hospitals to use the most cost-efficient 5–HT3 antiemetic that is clinically appropriate. We also anticipate that hospitals will continue to provide care that is aligned witht the best interests of the patient. We do not believe that our CY 2011 policy to apply the drug packaging threshold to 5–HT3 antiemetics will limit beneficiaries' ability to receive clinically appropriate drugs and biologicals.

Comment: One commenter suggested that CMS institute a packaging threshold exemption for antineoplastic agents and other anticancer therapeutic agents. The commenter believed that anticancer agents, as a class, are not appropriate for packaging because of the toxicity, side effects, potential interactions with other drugs, and level of patient specificity associated with these therapies. The commenter requested that CMS not apply the drug packaging threshold for anticancer agents and any product that is typically used in chemotherapy supportive care regimens. Instead the commenter requested that CMS provide separate payment for all these products in CY 2011.

Response: As we discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66757), the CY 2009 OPPS/ASC final rule with comment period (73 FR 68643), and the CY 2010 OPPS/ASC final rule with comment period (74 FR 60488), as we continue to explore the possibility of additional encounter-based or episode based payment in future years, we may consider additional options for packaging drug payment in the future. For example, a higher drug packaging threshold could eliminate existing disparities in payment methodologies for other drug groups and provide similar methods of payment across items in a group. Nevertheless, as discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68643), while we may be interested in alternative threshold methodologies for future ratesetting purposes, we realize that there are existing situations where drugs in a particular category vary in their payment treatment under the OPPS with some drugs packaged and other separately paid.

We continue to believe the challenges associated with categorizing drugs to assess them for differences in their OPPS payment methodologies are significant, and we do not agree that ensuring the same payment treatment for all drugs in any particular drug category is essential at this time. Therefore, it would not be appropriate at this time to take any additional steps to ensure that all drugs in a specific category, including antineoplastic agents, are all separately paid (or alternatively, all packaged), as requested by the commenter.

While some commenters requested that we seek feedback from interested stakeholders when the packaging threshold creates a payment methodology disparity between drugs within a single therapeutic class, we note that we provide an opportunity through the annual OPPS/ASC rulemaking cycle for public comment on the proposed packaging status of drugs and biologicals for the next calendar year. Further, we regularly accept meeting requests from interested providers and stakeholders on a variety of issues, and we address the APC Panel's recommendations in our annual proposed and final rules. We have often received public comments related to our proposed packaging status for particular drugs and biologicals, and we expect to continue to receive public comments regarding the proposed packaging status for drugs and biologicals in the future. In this manner, we would address specific concerns about the proposed packaging status for individual drugs and biologicals in the future, including those within a single therapeutic class where some drugs may be proposed to be packaged while others are proposed to be separately payable.

In summary, after consideration of the public comments we received, for CY

2011, we are finalizing our proposal to continue our policy of not exempting 5–HT3 antiemetics from the drug packaging threshold. We will pay separately for palonosetron hydrochloride for CY 2011 because its per day cost is greater than the $70 packaging threshold. In addition, we are not providing any exceptions to the standard drug packaging methodology for any class of drugs, including anticancer therapies, for CY 2011.

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

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

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60490 through 60491), we finalized a policy to make a single packaging determination for a drug, rather than an individual HCPCS code, when a drug has multiple HCPCS codes describing different dosages. We analyzed CY 2008 claims data for the HCPCS codes describing different dosages of the same drug or biological that were newly recognized in CY 2008 and found that our claims data would result in several different packaging determinations for different codes describing the same drug or biological. Furthermore, we found that our claims data would include few units and days for a number of newly recognized HCPCS codes, resulting in our concern that these data reflected claims from only a small number of hospitals, even though the drug or biological itself may be reported by many other hospitals under the most common HCPCS code. Based on these findings from our first available claims data for the newly recognized HCPCS codes, we believed that adopting our standard HCPCS code-specific packaging determinations for these codes could lead to payment incentives for hospitals to report certain HCPCS codes instead of others, particularly because we do not currently require hospitals to report all drug and biological HCPCS codes under the OPPS in consideration of our previous policy that generally recognized only the lowest dosage HCPCS code for a drug or biological for OPPS payment. For CY 2011, we continue to believe that adopting the standard HCPCS code-specific packaging determinations for these codes could lead to payment incentives for hospitals to report certain HCPCS codes for drugs instead of others. Making packaging determinations on a drug-specific basis eliminates these incentives and allows hospitals flexibility in choosing to report all HCPCS codes for different dosages of the same drug or only the lowest dosage HCPCS code. Therefore, in the CY 2011 OPPS/ASC proposed rule (75 FR46267), we proposed to continue our policy to make packaging determinations on a drug-specific basis, rather than a HCPCS code-specific basis, for those HCPCS codes that describe the same drug or biological but different dosages in CY 2011.

For CY 2011, in order to propose a packaging determination that is consistent across all HCPCS codes that describe different dosages of the same drug or biological, we aggregated both our CY 2009 claims data and our pricing information at ASP+6 percent across all of the HCPCS codes that describe each distinct drug or biological in order to determine the mean units per day of the drug or biological in terms of the HCPCS code with the lowest dosage descriptor. In the CY 2011 OPPS/ASC proposed rule (75 FR 46267), we noted that HCPCS codes J9093 (cyclophosphamide, lyophilized, 100 mg), J9094 (cyclophosphamide, lyophilized, 200 mg), J9095 (cyclophosphamide, lyophilized, 500 mg), J9096 (cyclophosphamide, lyophilized, 1g), and J9097 (cyclophosphamide, lyophilized, 2g) did not have pricing information available for the ASP methodology and, as is our current policy for determining the packaging status of other drugs, we used the mean unit cost available from fourth quarter CY 2009 claims data to make the packaging determinations for these drugs. For all other drugs and biologicals that have HCPCS codes describing different dosages, we then multiplied the weighted average ASP+6 percent or mean unit cost payment amount across all dosage levels of a specific drug or biological by the estimated units per day for all HCPCS codes that describe each drug or biological from our claims data to determine the estimated per day cost of each drug or biological at less than or equal to $70 (whereupon all HCPCS codes for the same drug or biological would be packaged) or greater than $70 (whereupon all HCPCS codes for the same drug or biological would be separately payable). The proposed packaging status of each drug and biological HCPCS code, to which this methodology would apply was displayed in Table 24 of the proposed rule.

We did not receive any public comments on our proposal to make packaging determinations on a drug-specific basis for CY 2011. Therefore, we are finalizing our CY 2011 proposal, without modification, to make a single packaging determination for a drug, rather than an individual HCPCS code, when a drug has multiple HPCS codes describing different dosages. For this CY 2011 final rule with comment period, we are finalizing our proposal to use the mean unit cost available from CY 2009 claims data to make the packaging determination for HCPCS codes J9097. We discuss the final status indicator for HCPCS code J9097 and the discontinuation of HCPCS codes J9093, J9094, J9095 and J9096 for CY 2011 below.

For CY 2011, we have aggregated both our CY 2009 claims data and our pricing information at ASP+5 percent across all of the HCPCS codes that describe each distinct drug or biological in order to determine the mean units per day of the drug or biological in terms of the HCPCS code with the lowest dosage descriptor. We then multiplied the weighted average ASP+5 percent or mean unit cost payment amount across all dosage levels of a specific drug or biological by the estimated units per day for all HCPCS codes that describe each drug or biological from our claims data to

determine the estimated per day cost of each drug or biological at less than or equal to $70 (whereupon all HCPCS codes for the same drug or biological would be packaged) or greater than $70 (whereupon all HCPCS codes for the same drug or biological would be separately payable). The final CY 2011 packaging status of each drug and biological HCPCS code to which this methodology applies is displayed in Table 31 below.

We note that several HCPCS codes that were previously proposed in the CY 2011 OPPS/ASC proposed rule (75 FR 46266 through 46270) to be treated as drugs with multiple HCPCS codes with multiple dosage descriptors and, therefore, calculated using the methodology described above, are being deleted for CY 2011. Billing for these drugs will continue under a new or already existing code as described below, for CY 2011: HCPCS codes J0970 (Injection, estradiol valerate, up to 40 mg) and J1390 (Injection, estradiol valerate, up to 20 mg) have been deleted for CY 2011 and billing for these drugs will continue under currently existing HCPCS code J1380 (Injection, estradiol valerate, up to 10 mg). In order to make a packaging determination for HCPCS code J1380, we used updated hospital claims data from HCPCS codes J0970, J1390, and J1380 and ASP pricing information to determine the estimated per day cost for the drug described above. Because the estimated per day cost was less than our CY 2011 packaging threshold of $70, we assigned status indicator "N" to HCPCS code J1380 for CY 2011.

HCPCS codes J1470 (Injection, gamma globulin, intramuscular 2 cc), J1480 (Injection, gamma globulin, intramuscular 3 cc), J1490 (Injection, gamma globulin, intramuscular 4 cc), J1500 (Injection, gamma globulin, intramuscular 5 cc), J1510 (Injection, gamma globulin, intramuscular 6 cc), J1520 (Injection, gamma globulin, intramuscular 7 cc), J1530 (Injection, gamma globulin, intramuscular 8 cc), J1540 (Injection, gamma globulin, intramuscular 9 cc), and J1550 (Injection, gamma globulin, intramuscular 10 cc) have been deleted for CY 2011 and billing for these drugs will continue under two currently existing HCPCS codes, J1460 (Injection, gamma globulin, intramuscular, 1 cc) and J1560 (Injection, gamma globulin, intramuscular over 10 cc). In order to make a packaging determination for HCPCS code J1460 and J1560, we used updated hospital claims data from HCPCS codes J1460, J1470, J1480, J1490, J1500, J1510, J1520, J1530, J1540, J1550 and J1560 and ASP pricing information to determine the estimated per day cost for the drugs described above. Because the estimated per day cost was more than our CY 2011 packaging threshold of $70, we assigned status indicator "K" to HCPCS codes J1460 and J1560 for CY 2011.

HCPCS codes J2321 (Injection, nandrolone decanoate, up to 100 mg) and J2322 (Injection, nandrolone decanoate, up to 200 mg) have been deleted for CY 2011 and billing for these drugs will continue under already existing HCPCS code J2320 (Injection, nandrolone decanoate, up to 50 mg). In order to make a packaging determination for HCPCS code J2320, we used updated hospital claims data from HCPCS codes J2320, J2321, and J2322 and ASP pricing information to determine the estimated per day cost for the drug described above. Although the estimated per day cost was less than our CY 2011 packaging threshold of $70, we are assigning status indicator "K" to HCPCS code J2320 for CY 2011, based upon the policy that was finalized in section V.B.2.b. of this final rule with comment period for HCPCS codes for drugs and nonimplantable biologicals for which we paid separately in CY 2010 and that were proposed for separate payment in CY 2011 and then have per day costs equal to or less than $70, based on the updated ASPs and hospital claims data used for this CY 2011 OPPS/ASC final rule with comment period. We describe the assignment of J2320 to status indicator "K" above.

HCPCS code J9062 (Cisplatin, 50 mg) has been deleted for CY 2011 and billing for this drug will continue under existing HCPCS code J0960 (Cisplatin, powder or solution, per 10 mg). In order to make a packaging determination for HCPCS code J9060, we used updated hospital claims data from HCPCS codes J0960 and J9062 and ASP pricing information to determine the estimated per day cost for the drug described above. Because the estimated per day cost was less than our CY 2011 packaging threshold of $70 and because these codes were assigned status indicator "N" for the CY 2011 proposed rule, we assigned status indicator "N" to HCPCS code J0960 for CY 2011.

HCPCS codes J9080 (Cyclophosphamide, 200 mg), J9090 (Cyclophosphamide, 500 mg), J9091 (Cyclophosphamide, 1.0 gram), J9092 (Cyclophosphamide, 2.0 gram), J9093 (Cyclophosphamide, lyophilized, 100 mg), J9094 (Cyclophosphamide, lyophilized, 200 mg), J9095 (Cyclophosphamide, lyophilized, 500 mg), J9096 (Cyclophosphamide, lyophilized, 1.0 gram), and J9097 (Cyclophosphamide, lyophilized, 2.0 gram) have been deleted for CY 2011 and billing for these drugs will continue under existing HCPCS code J9070 (Cyclophosphamide, 100 mg). In order to make a packaging determination for HCPCS code J9070, we used updated hospital claims data from HCPCS codes J9070, J9080, J9090, J9091, J9092, J9093, J9094, J9095, J9096, and J9097 and ASP pricing information to determine the estimated per day cost for the drug described above. Because the estimated per day cost was less than our CY 2011 packaging threshold of $70 and because these codes were assigned status indicator "N" for the CY 2011 proposed rule, we assigned status indicator "N" to HCPCS code J9070 for CY 2011 in this final rule with comment period.

HCPCS code J9110 (Injection, cytarabine, 500 mg) has been deleted for CY 2011 and billing for this drug will continue under existing HCPCS code J9100 (Injection, cytarabine, 100 mg). In order to make a packaging determination for HCPCS code J9100, we used updated hospital claims data from HCPCS codes J9100 and J9110 and ASP pricing information to determine the estimated per day cost for the drug described above. Because the estimated per day cost was less than our CY 2011 packaging threshold of $70 and because these codes were assigned status indicator "N" for the CY 2011 proposed rule, we assigned status indicator "N" to HCPCS code J9100 for CY 2011 in this final rule with comment period.

HCPCS code J9140 (Dacarbazine, 100 mg) has been deleted for CY 2011 and billing for this drug will continue under HCPCS code J9130 (Injection, dacarbazine, 200 mg). In order to make a packaging determination for HCPCS code J9130, we used updated hospital claims data from HCPCS codes J9130 and J9140 and ASP pricing information to determine the estimated per day cost for the drug described above. Because the estimated per day cost was less than our CY 2011 packaging threshold of $70 and because these codes were assigned status indicator "N" for the CY 2011 proposed rule, we assigned status indicator "N" to HCPCS code J9130 for CY 2011 in this final rule with comment period.

HCPCS codes J9290 (Mitomycin, 20 mg) and J9291 (Mitomycin, 40 mg) have been deleted for CY 2011 and billing for these drugs will continue under existing HCPCS code J9280 (Mitomycin, 5 mg). In order to make a packaging determination for HCPCS code J9280, we used updated hospital claims data from HCPCS codes J9280, J9290, and J9291 and ASP pricing information to determine the estimated per day cost for

the drug described above. Because the estimated per day cost was more than our CY 2011 packaging threshold of $70, we assigned status indicator "K" to HCPCS code J9280 for CY 2011.

HCPCS codes J9375 (Vincristine sulfate, 2 mg) and J9380 (Viscristine sulfate, 5 mg) have been deleted for CY 2011 and billing for these drugs will continue under existing HCPCS code J9370 (Vincristine sulfate, 1 mg). In order to make a packaging determination for HCPCS code J9370, we used updated hospital claims data from HCPCS codes J9370, J9375, and J9380 and ASP pricing information to determine the estimated per day cost for the drug described above. Because the estimated per day cost was less than our CY 2011 packaging threshold of $70 and because these codes were assigned status indicator "N" for the CY 2011 proposed rule, we assigned status indicator "N" to HCPCS code J9370 for CY 2011 in this final rule with comment period.

We note that, in the CY 2011 OPPS/ASC proposed rule, HCPCS codes J0560 (Injection, penicillin g benzathine, up to 600,000 units), J0570 (Injection, penicillin g benzathine, 1,200,000 units), and J0580 (Injection, penicillin g benzathine, up to 2,400,000 units) were erroneously omitted from Table 24 of the proposed rule. As we did for CY 2010 and several years before that, we continued to treat these as drugs with multiple HCPCS codes with multiple dosage descriptors; therefore, we calculated using the methodology described above for our calculations for the CY 2011 proposed rule. The payment rates for these HCPCS codes were given in Addendum B to the CY 2011 OPPS/ASC proposed rule. For this CY 2011 OPPS/ASC final rule with comment period, HCPCS codes J0560, J0570, and J0580 are being deleted and billing for these drugs will continue under new HCPCS code J0561 (Injection, penicillin g benzathine, 100,00 units). In order to make a packaging determination for HCPCS code J0561, we used updated hospital claims data from HCPCS codes J0560, J0570, and J0580 and ASP pricing information to determine the estimated per day cost for the drug described above. Because the estimated per day cost was less than our CY 2011 packaging threshold of $70 and because these codes were assigned status indicator "N" for the CY 2011 proposed rule, we assigned status indicator "N" to HCPCS code J0561 for CY 2011 in this final rule with comment period.

Table 31 below displays the packaging status of each drug and biological HCPCS code determined under the finalized package determination methodology. We note that HCPCS codes J0560, J0570, J0580, J0970, J1390, J1470, J1480, J1490, J1500, J1510, J1520, J1530, J1540, J1550, J2321, J2322, J9062, J9080, J9090, J9091, J9092, J9093, J9094, J9095, J9096, J9097, J9110, J9140, J9290, J9291, J9375, and J9380 are not displayed in Table 31 below because they are deleted for CY 2011.

TABLE 31—HCPCS CODES TO WHICH THE CY 2011 DRUG–SPECIFIC PACKAGING DETERMINATION METHODOLOGY APPLIES

CY 2011 HCPCS Code	CY 2011 Long descriptor	CY 2011 SI
C9257	Injection, bevacizumab, 0.25 mg	K
J9035	Injection, bevacizumab, 10 mg	K
J1380	Injection, estradiol valerate, up to 10 mg	N
J1020	Injection, methylprednisolone acetate, 20 mg	N
J1030	Injection, methylprednisolone acetate, 40 mg	N
J1040	Injection, methylprednisolone acetate, 80 mg	N
J1070	Injection, testosterone cypionate, up to 100 mg	N
J1080	Injection, testosterone cypionate, 1 cc, 200 mg	N
J1440	Injection, filgrastim (g-csf), 300 mcg	K
J1441	Injection, filgrastim (g-csf), 480 mcg	K
J1460	Injection, gamma globulin, intramuscular, 1 cc	K
J1560	Injection, gamma globulin, intramuscular over 10 cc	K
J1642	Injection, heparin sodium, (heparin lock flush), per 10 units	N
J1644	Injection, heparin sodium, per 1000 units	N
J1850	Injection, kanamycin sulfate, up to 75 mg	N
J1840	Injection, kanamycin sulfate, up to 500 mg	N
J2270	Injection, morphine sulfate, up to 10 mg	N
J2271	Injection, morphine sulfate, 100mg	N
J2320	Injection, nandrolone decanoate, up to 50 mg	K
J2788	Injection, rho d immune globulin, human, minidose, 50 micrograms (250 i.u.)	K
J2790	Injection, rho d immune globulin, human, full dose, 300 micrograms (1500 i.u.)	K
J2920	Injection, methylprednisolone sodium succinate, up to 40 mg	N
J2930	Injection, methylprednisolone sodium succinate, up to 125 mg	N
J3120	Injection, testosterone enanthate, up to 100 mg	N
J3130	Injection, testosterone enanthate, up to 200 mg	N
J3471	Injection, hyaluronidase, ovine, preservative free, per 1 usp unit (up to 999 usp units)	N
J3472	Injection, hyaluronidase, ovine, preservative free, per 1000 usp units	N
J7050	Infusion, normal saline solution , 250 cc	N
J7040	Infusion, normal saline solution, sterile (500 ml=1 unit)	N
J7030	Infusion, normal saline solution , 1000 cc	N
J7515	Cyclosporine, oral, 25 mg	N
J7502	Cyclosporine, oral, 100 mg	N
J8520	Capecitabine, oral, 150 mg	K
J8521	Capecitabine, oral, 500 mg	K
J9060	Cisplatin, powder or solution, per 10 mg	N
J9070	Cyclophosphamide, 100 mg	N
J9100	Injection, cytarabine, 100 mg	N
J9130	Injection, dacarbazine, 100 mg	N

TABLE 31—HCPCS CODES TO WHICH THE CY 2011 DRUG–SPECIFIC PACKAGING DETERMINATION METHODOLOGY APPLIES—Continued

CY 2011 HCPCS Code	CY 2011 Long descriptor	CY 2011 SI
J9250	Methotrexate sodium, 5 mg	N
J9260	Methotrexate sodium, 50 mg	N
J9280	Mitomycin, 5 mg	K
J9370	Vincristine sulfate, 1 mg	N
Q0164	Prochlorperazine maleate, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour doseage regimen.	N
Q0165	Prochlorperazine maleate, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour doseage regimen.	N
Q0167	Dronabinol, 2.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anit0emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.	N
Q0168	Dronabinol, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anit0emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.	N
Q0169	Promethazine hydrochloride, 12.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.	N
Q0170	Promethazine hydrochloride, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.	N
Q0171	Chlorpromazine hydrochloride, 10 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.	N
Q0172	Chlorpromazine hydrochloride, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotheapy treatment, not to exceed a 48-hour dosage regimen.	N
Q0175	Perphenazine, 4 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.	N
Q0176	Perphenazine, 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.	N
Q0177	Hydroxyzine pamoate, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.	N
Q0178	Hydroxyzine pamoate, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exeed a 48-hour dosage regimen.	N

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

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

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

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

We believe that packaging the payment for diagnostic radiopharmaceuticals and contrast agents into the payment for their associated procedures continues to be appropriate for CY 2011. As discussed in more detail in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68645 through 68649), we presented several reasons supporting our initial policy to package payment of diagnostic radiopharmaceuticals and contrast agents into their associated procedures on a claim. Specifically, we stated that we believed packaging was appropriate because: (1) The statutorily required OPPS drug packaging threshold has expired; (2) we believe that diagnostic radiopharmaceuticals and contrast agents function effectively as supplies that enable the provision of an independent service; and (3) section 1833(t)(14)(A)(iii) of the Act requires that payment for specified covered outpatient drugs (SCODs) be set prospectively based on a measure of average hospital acquisition cost. As we stated in the CY 2011 OPPS/ASC proposed rule, for these reasons, we

believe it is appropriate to continue to treat diagnostic radiopharmaceuticals and contrast agents differently from other SCODs for CY 2011. Therefore, in the CY 2011 OPPS/ASC proposed rule (75 FR 46271), we proposed to continue packaging payment for all contrast agents and diagnostic radiopharmaceuticals, collectively referred to as "policy-packaged" drugs, regardless of their per day costs, for CY 2011. We also proposed to continue to package the payment for diagnostic radiopharmaceuticals into the payment for the associated nuclear medicine procedure and to package the payment for contrast agents into the payment of the associated echocardiography imaging procedure, regardless of whether the contrast agent met the OPPS drug packaging threshold. We refer readers to the CY 2010 OPPS/ASC final rule with comment period for a detailed discussion of nuclear medicine and echocardiography services (74 FR 35269 through 35277).

Comment: Several commenters expressed concerns about the fluctuation in data for echocardiography APCs used with contrast codes, particularly the reductions in median cost from CY 2010. The commenters believed this fluctuation in the data is due to the lack of familiarity among hospital coders on contrast codes and C-codes used for contrast enhanced echocardiography. They pointed out that CY 2009 is only the second year of claims data for the new echocardiography CPT codes and associated C-codes. The commenters also cited a smaller number of "days" for contrast agents used with echocardiography, HCPCS codes Q9956 (Injection, octafluoropropane microspheres, per ml) and Q9957 (Injection, perflutren lipid microspheres, per ml), in the published "brachy-blood-drug" median cost file that CMS published with the proposed rule than total frequency of services for contrast enhanced echocardiography. In addition, the commenters stated that the average cost of HCPCS codes Q9957 and Q9956 for any given contrast enhanced echocardiography is approximately $120, and that the observed difference in median cost between APC 0128 (Echocardiogram with Contrast) and APC 0269 (Level II Echocardiogram without Contrast) is approximately $100, suggesting that the difference in cost for with and without contrast is not sufficient to cover the cost of the contrast agent. Therefore, these commenters concluded that the reduction in the median cost for APC 0128 in the CY 2011 proposed rule is due to the fact that the median cost for these codes do not contain the cost of contrast agents. A few commenters suggested that CMS institute a claims edit that would require a code for contrast on claims that contain a procedure code specified as "with" contrast. Another commenter suggested that CMS limit fluctuations that occur from year to year on APC payment rates to no more than 10 percent for any unexplained and substantial changes in cost data.

Response: We find no evidence that would suggest that the fluctuations in cost data for echocardiography APCs are due to incorrect hospital billing practices. Because some of the echocardiography codes were new for CY 2009, we believe the observed reduction in median cost for CY 2011 is due to the difference between CMS' best estimate of a median cost for these echocardiography codes based on simulated CY 2008 claims data for CY 2010 payment, and median cost based on actual hospital billing for these echocardiography codes in CY 2009 for CY 2011 payment. Specifically, while most echocardiography codes and associated C-codes for contrast enhanced echocardiography were implemented in CY 2008, the CPT code 93306 (Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components) was not implemented until CY 2009 and incorporated services previously described in CY 2008 by three CPT codes: 93307 (Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete); 93320 (Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete); and 93325 (Doppler echocardiography color flow velocity mapping). As we discussed in our CY 2010 OPPS/ASC final rule with comment period (74 FR 60374), we simulated a median cost for both CPT code 93306 and associated HCPCS code C8929, which describe services billed with CPT code 93306 but enhanced with contrast. For CY 2009 (73 FR 68542) and CY 2010 (74 FR 60374), we simulated a median cost for CPT code 93306 and HCPCS code C8929 based on the long descriptor for the new code, indentifying claims with CPT codes 93307, 93220, and 93225 as representing the costs of CPT code 93306. We simulated the CY 2010 medians for 93306 and C8929 to provide the most accurate payment possible based on available cost information in the CY 2008 claims without having actual charge data for 93306 and C8929 from hospitals.

CPT code 93306 and HCPCS code C8929 are the highest volume echocardiography codes, and their median costs largely drive the median cost of their respective APCs for CY 2011: APC 0269 (Level II Echocardiogram without Contrast) and APC 0128 (Echocardiogram with Contrast). Therefore, changes in the median cost of 93306 and C8929 will significantly impact the median cost for those APCs. Because CY 2011 OPPS ratesetting is based on CY 2009 claims data, as discussed in section II.A. of this final rule with comment period, the CY 2011 median cost data for CPT code 93306 and HCPCS code C8929 represent the first year of actual claims data for these services. For this reason, we believe that our CY 2011 estimated cost for CPT code 93306 and HCPCS code C8929 based on CY 2009 claim charges and the most recent cost report data available is more accurate than CY 2010 and CY 2009 simulated median costs. We note that almost all of the median cost estimates for all of the other contrast enhanced echocardiography services in APC 0128, which did not rely on a simulated median cost in CY 2010, increase between CY 2010 and CY 2011.

Commenters suggested that the discrepancy between observed frequency of days for the two HCPCS for contrast agents used with echocardiography, HCPCS codes Q9956 and Q9957, indicates that the median costs for APC 0128 do not reflect the cost of contrast. We do not observe a sizable discrepancy between observed frequency of days, instead, we observe fairly comparable numbers of procedures for contrast enhanced echocardiography and the number of days associated with these contrast agents. Specifically, we observe approximately 53,000 procedures for contrast enhanced echocardiography and approximately 48,000 days of administration for HCPCS codes Q9956 and Q9957 in our final rule claims data. Finally, we believe that an observed differential in payment of approximately $100 between the APC median cost for APC 0128 of approximately $494 and APC 0269 of approximately $398 in the final rule with comment period both demonstrates that hospitals are including the cost of contrast in their charges for HCPCS code C8929 and that this amount is sufficient to capture the cost of contrast in a prospective payment system that includes packaging and averaging. In summary, we have no reason to believe that these first years of actual costs for

CPT code 93306 and HCPCS code C8929 are inaccurate. For this reason, we do not believe there is any need to edit for contrast agents, nor do we believe that we should moderate these observed reductions in median cost, because, we believe, this year's cost estimate is more accurate than the simulated median costs used in previous years.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68634), we began packaging the payment for all nonpass-through implantable biologicals into payment for the associated surgical procedure. Because implantable biologicals may sometimes substitute for nonbiological devices, we noted that if we were to provide separate payment for implantable biologicals without pass-through status, we would potentially be providing duplicate device payment, both through the packaged nonbiological device cost already included in the surgical procedure's payment and the separate biological payment. We concluded that we saw no basis for treating implantable biological and nonbiological devices without pass-through status differently for OPPS payment purposes, because both are integral to and supportive of the separately paid surgical procedures in which either may be used. Therefore, in CY 2009, we adopted a final policy to package payment for all nonpass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice), similar to our longstanding policy that packages payment for all implantable nonbiological devices without pass-through status. We finalized a policy in CY 2010 to package payment for nonpass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) into the body, known as devices. In the CY 2011 OPPS/ASC proposed rule (75 FR 46271), for CY 2011, we proposed to continue to package payment for nonpass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) into the body, referred to as devices. In accordance with this proposal, two of the products with expiring pass-through status for CY 2011 are biologicals that are solely surgically implanted according to their FDA-approved indications. These products are described by HCPCS codes C9356 (Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter) and C9359 (Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc). Similar to the two implantable biologicals with expiring pass-through status in CY 2010 that were discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60459 through 60499), we believe that the two biologicals described by HCPCS codes C9356 and C9359 with expiring pass-through status for CY 2011 differ from other biologicals paid under the OPPS, in that they specifically function as surgically implanted devices. As a result of the CY 2010 packaged payment methodology for all nonpass-through implantable biologicals, we proposed to package payment for HCPCS codes C9356 and C9359 and assign them status indicator "N" for CY 2011. In addition, any new biologicals without pass-through status that are surgically inserted or implanted (through a surgical incision or a natural orifice) would be packaged in CY 2011. Moreover, for nonpass-through biologicals that may sometimes be used as implantable devices, we continue to instruct hospitals to not bill separately for the HCPCS codes for the products when used as implantable devices. This reporting ensures that the costs of these products that may be, but are not always, used as implanted biologicals are appropriately packaged into payment for the associated implantation procedures.

Comment: Several commenters objected to CMS' proposal to package payment for all diagnostic radiopharmaceuticals and contrast agents in CY 2011. A number of commenters stated that diagnostic radiopharmaceuticals and contrast agents with per day costs over the proposed OPPS drug packaging threshold are defined as SCODs and, therefore, should be assigned separate APC payments. In particular, the commenters questioned CMS' authority to classify groups of drugs, such as diagnostic radiopharmaceuticals and contrast agents, and implement packaging and payment policies that do not reflect their status as SCODs. Several comments disagreed with CMS' labeling of radiopharmaceuticals as supplies and stated instead that they should be treated as other SCODs. The commenters recommended that diagnostic radiopharmaceuticals should be subject to the same per day cost drug packaging threshold that applies to other drugs, in order to determine whether their payment would be packaged or made separately.

Response: As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66766), the CY 2009 OPPS/ASC final rule with comment period (73 FR 68645 and the CY 2010 OPPS/ASC final rule with comment period (74 FR 35323), we continue to believe that diagnostic radiopharmaceuticals and contrast agents are different from other drugs and biologicals for several reasons. We note that the statutorily required OPPS drug packaging threshold has expired, and we continue to believe that diagnostic radiopharmaceuticals and contrast agents function effectively as supplies that enable the provision of an independent service and are always ancillary and supportive to an independent service, rather than serving themselves as the therapeutic modality. We packaged their payment in CYs 2008, 2009, and 2010 as ancillary and supportive services in order to provide incentives for greater efficiency and to provide hospitals with additional flexibility in managing their resources. In order for payment to be packaged, it is not necessary that all products be interchangeable in every case, and we recognized that, in some cases, hospitals may utilize higher cost products and, in some cases, lower cost products, taking into consideration the clinical needs of the patient and efficiency incentives. While we recognize this variability from case to case, on average under a prospective payment system, we expect payment to pay appropriately for the services furnished. In the past, we have classified different groups of drugs for specific payment purposes, as evidenced by our CY 2005 through CY 2009 policy regarding 5–HT3 antiemetics and their exemption from the drug packaging threshold. We note that we treat diagnostic radiopharmaceuticals and contrast agents as "policy-packaged" drugs because our policy is to package payment for all of the products in the category.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68634), we also began packaging the payment for all nonpass-through implantable biologicals into payment for the associated surgical procedure because we consider these products to always be ancillary and supportive to independent services, similar to implantable nonbiological devices that are always packaged. Therefore, we currently package payment for nonpass-through implantable biologicals, also known as devices that are surgically inserted or implanted (through a surgical incision or a natural orifice) into the body. As we stated in the CY 2011 OPPS/ASC proposed rule (75 FR 46267), we

continue to believe that payment should be packaged for nonpass-through implantable biologicals for CY 2011.

Although our final CY 2009 policy which we are continuing for CY 2011, as discussed below, packages payment for all diagnostic radiopharmaceuticals, contrast agents, and nonpass-through implantable biologicals into the payment for their associated procedures, we are continuing to provide payment for these items in CY 2011 based on a proxy for average acquisition cost, as we did in CY 2009. We continue to believe that the line-item estimated cost for a diagnostic radiopharmaceutical, contrast agent, or nonpass-through implantable biologicals in our claims data is a reasonable approximation of average acquisition and preparation and handling costs for diagnostic radiopharmaceuticals, contrast agents, and nonpass-through implantable biologicals, respectively. As we discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68645), we believe that hospitals have adapted to the CY 2006 coding changes for radiopharmaceuticals and responded to our instructions to include charges for radiopharmaceutical handling in their charges for the radiopharmaceutical products. Further, because the standard OPPS packaging methodology packages the total estimated cost of each radiopharmaceutical, contrast agent, or nonimplantable biological on each claim (including the full range of costs observed on the claims) with the cost of associated procedures for ratesetting, this packaging approach is consistent with considering the average cost for radiopharmaceuticals, contrast agents, or nonpass-through implantable biologicals, rather than the median cost. In addition, as we noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68646), these drugs, biologicals, or radiopharmaceuticals for which we have not established a separate APC and therefore, for which payment would be packaged rather than separately provided under the OPPS, could be considered to not be SCODs. Similarly, drugs and biologicals with per day costs of less than $70 in CY 2011 that are packaged and for which a separate APC has not been established also would not be SCODs. Similarly, drugs and biologicals with per day costs of less than $70 in CY 2011 that are packaged and for which a separate APC has not been established also would not be SCODs. This reading is consistent with our final payment policy whereby we package payment for diagnostic radiopharmaceuticals, contrast agents, and nonpass-through implantable biologicals and provide payment for these products through payment for their associated procedures.

Comment: Several commenters disagreed with the proposal to distinguish between diagnostic and therapeutic radiopharmaceuticals for payment purposes under the OPPS. The commenters noted that CMS' identification of HCPCS codes A9542 (Indium In-111 ibritumomabituxetan, diagnostic, per study dose, up to 5 millicuries) and A9544 (Iodine I–131 tositumomab, diagnostic, per study dose) as diagnostic radiopharmaceuticals was inappropriate because these radiopharmaceuticals function as dosimetric radiopharmaceuticals and not as diagnostic radiopharmaceuticals. A few commenters explained that these radiopharmaceutical products are used as part of a therapeutic regimen and, therefore, should be considered therapeutic for OPPS payment purposes.

Response: As discussed above and in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66641), the CY 2009 OPPS/ASC final rule with comment period (73 FR 68645), and the CY 2010 OPPS/ASC final rule with comment period (74 FR 60498), we classified each radiopharmaceutical into one of the two groups according to whether its long descriptor contained the term "diagnostic" or "therapeutic". HCPCS codes A9542 and A9544 both contain the term "diagnostic" in their long code descriptors. Therefore, according to our established methodology, we continue to classify them as diagnostic for the purposes of CY 2011 OPPS payment. While we understand that these items are provided in conjunction with additional supplies, imaging tests, and therapeutic radiopharmaceuticals for patients already diagnosed with cancer, we continue to believe that the purpose of administering the products described by HCPCS codes A0542 and A9544 is diagnostic in nature. As we first stated in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66641), we continue to believe that HCPCS codes A9542 and A9544 are diagnostic radiopharmaceuticals. While they are not used to diagnose diseases, they are used to determine whether future therapeutic services would be beneficial to the patient and to determine how to proceed with therapy. While a group of associated services may be considered a therapeutic regimen by some commenters, HCPCS codes A9542 and A9544 are provided in conjunction with a series of nuclear medicine imaging scans. Many nuclear medicine studies using diagnostic radiopharmaceuticals are provided to patients who already have an established diagnosis. We continue to consider HCPCS codes A9542 and A9544 to be diagnostic because these items are provided for the purpose of a diagnostic imaging procedure and are used to identify the proposed dose of the therapeutic agent to be provided at a later time.

Comment: Some commenters recommended using the ASP methodology to make payment for nonpass-through diagnostic radiopharmaceuticals, noting that it would be inconsistent for CMS to treat diagnostic radiopharmaceuticals as "drugs" for pass-through payment purposes, provide payment for diagnostic radiopharmaceuticals that have pass-through status based on the ASP methodology, and, then, after the diagnostic radiopharmaceutical's pass-through payment status expires, package the costs included in historical hospital claims data, rather than use the ASP methodology to pay for the product and treat the drug as a supply. A few commenters recommended that CMS pay for diagnostic radiopharmaceuticals under the pass-through policy as we currently pay for A9582 (Iodine I–123 iobenguane, diagnostic, per study dose, up to 15 millicuries) and thereby issue an offset amount and no coinsurance amount. One commenter suggested that diagnostic radiopharmaceuticals could be paid separately as therapeutic radiopharmaceuticals are paid, which would allow manufacturers to voluntarily submit ASP data, and then default to the mean unit cost when ASP data are unavailable.

Response: As we stated above, the statutorily required OPPS drug packaging threshold has expired, and we continue to believe that diagnostic radiopharmaceuticals and contrast agents are always ancillary and supportive to an independent service, rather than services themselves as the therapeutic modality. We disagree with commenters who suggest that nonpass-through diagnostic radiopharmaceuticals should be paid under the ASP methodology, that nonpass-through diagnostic radiopharmaceuticals be paid as pass-through drugs and biologicals, or that nonpass-through diagnostic radiopharmaceuticals should be paid similarly to therapeutic radiopharmaceuticals. We continue to believe that nonpass-through diagnostic radiopharmaceuticals and contrast agents function effectively as supplies that enable the provision of an independent service. As we noted in the CY 2009 OPPS/ASC final rule with

comment period (73 FR 68646), and restate above, drugs, biologicals, or radiopharmaceuticals for which we have not established a separate APC, and which will therefore receive packaged payment under the OPPS, could be considered to not be SCODs. We are continuing to provide payment for these items in CY 2011 based on a proxy for average acquisition cost. We continue to believe that the line-item estimated cost for a diagnostic radiopharmaceutical, contrast agent, or nonpass-through implantable biologicals in our claims data is a reasonable approximation of average acquisition and preparation and handling costs for diagnostic radiopharmaceuticals, contrast agents and nonpass-through implantable biologicals, respectively. Therefore, we do not believe that diagnostic radiopharmaceuticals should be paid separately under the OPPS. We believe they are appropriately packaged into a single aggregate payment for the accompanying service provided.

Comment: A few commenters recommended that CMS provide separate payment for all diagnostic radiopharmaceuticals with a median per day cost greater than $200. The commenters believed that this recommendation is most consistent with the APC Panel's recommendation to CMS at the Panel's September 2007 meeting.

Response: As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60499), at the September 2007 APC Panel meeting, the APC Panel recommended that CMS package radiopharmaceuticals with a median per day cost of less than $200 but pay separately for radiopharmaceuticals with a median per day cost of $200 or more. In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66638), we did not accept the APC Panel's recommendation, citing an inability to determine an empirical basis for paying separately for radiopharmaceuticals with a median per day cost in excess of $200. Instead, as proposed, for CY 2008, we finalized the packaging of payment for all diagnostic radiopharmaceuticals. Consistent with the CY 2011 OPPS/ASC proposed rule, for this final rule with comment period, we continue to believe that diagnostic radiopharmaceuticals are ancillary and supportive to the nuclear medicine procedures in which they are used and that their costs should be packaged into the primary procedures with which they are associated. We do not believe it would be appropriate to set a cost threshold for packaging diagnostic radiopharmaceuticals because, regardless of their per day cost, they are always supportive of an independent procedure that is the basis for administration of the diagnostic radiopharmaceutical.

After consideration of the public comments we received, we are finalizing our CY 2011 proposals, without modification, to continue to package payment for all nonpass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals that are surgically inserted or implanted into the body through a surgical incision or a natural orifice, regardless of their per day costs. Given the inherent function of contrast agents and diagnostic radiopharmaceuticals as ancillary and supportive to the performance of an independent procedure and the similar functions of implantable biologicals and nonbiological devices as integral to and supportive of the separately paid surgical procedures in which either may be used we continue to view the packaging of payment for contrast agents, diagnostic radiopharmaceuticals, and implantable biologicals as a logical expansion of packaging payment for drugs and biologicals. In addition, as we initially established in the CY 2008 OPPS/ASC final rule with comment period, (72 FR 66768), we will continue to identify diagnostic radiopharmaceuticals specifically as those Level II HCPCS codes that include the term "diagnostic" along with a radiopharmaceutical in their long code descriptors, and therapeutic radiopharmaceuticals as those Level II HCPCS codes that include the term "therapeutic" along with a radiopharmaceutical in their long code descriptors. Finally, we are finalizing our proposal to package payment for HCPCS C9356 and C9359 and to assign status indicator "N" for CY 2011. In addition, any new biological lacking pass-through status that is surgically inserted or implanted through a surgical incision or natural orifice would be packaged in CY 2011. For more information on how we set CY 2011 payment rates for nuclear medicine procedures in which diagnostic radiopharmaceuticals are used and echocardiography services provided with and without contrast agents, we refer readers to the CY 2010 OPPS/ASC final rule with comment period for a detailed discussion of nuclear medicine and echocardiography services (74 FR 35269 through 35277).

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

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

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

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

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

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

Section 1833(t)(14)(E) of the Act provides for an adjustment in OPPS payment rates for overhead and related expenses, such as pharmacy services and handling costs. Section 1833(t)(14)(E)(i) of the Act required MedPAC to study pharmacy overhead and to make recommendations to the

Secretary regarding whether, and if so how, a payment adjustment should be made to compensate hospitals for them. Section 1833(t)(14)(E)(ii) of the Act authorizes the Secretary to adjust the weights for ambulatory procedure classifications for SCODs to take into account the findings of the MedPAC study.

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

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

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

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

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

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

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

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68091), we finalized our proposed policy to provide a single payment of ASP+6 percent for the hospital's acquisition cost for the drug or biological and all associated pharmacy overhead and handling costs. The ASP+6 percent rate that we finalized was higher than the equivalent average ASP-based amount calculated from claims of ASP+4 percent according to our standard drug payment methodology, but we adopted payment at ASP+6 percent for stability while we continued to examine the issue of the costs of pharmacy overhead in the HOPD.

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

For CY 2009, we proposed to pay separately payable drugs and biologicals at ASP+4 percent, including both SCODs and other drugs without CY 2009 OPPS pass-through status, based on our standard drug payment methodology. We also proposed to split the "Drugs Charged to Patients" cost center into two cost centers: One for

drugs with high pharmacy overhead costs and one for drugs with low pharmacy overhead costs (73 FR 41492). We noted that we expected that CCRs from the proposed new cost centers would be available in 2 to 3 years to refine OPPS drug cost estimates by accounting for differential hospital markup practices for drugs with high and low overhead costs. After consideration of the public comments received and the APC Panel recommendations, we finalized a CY 2009 policy (73 FR 68659) to provide payment for separately payable nonpass-through drugs and biologicals based on costs calculated from hospital claims at a 1-year transitional rate of ASP+4 percent, in the context of an equivalent average ASP-based payment rate of ASP+2 percent calculated according to our standard drug payment methodology from the final rule claims data and cost report data. We did not finalize our proposal to split the single standard "Drugs Charged to Patients" cost center into two cost centers largely due to concerns raised to us by hospitals about the associated administrative burden. Instead, we indicated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68659) that we would continue to explore other potential approaches to improve our drug cost estimation methodology, thereby increasing payment accuracy for separately payable drugs and biologicals.

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

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

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

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

We acknowledged that the observed combined payment for acquisition and pharmacy overhead costs of ASP–2 percent for separately payable drugs and biologicals may be too low and ASP+247 percent for coded packaged drugs and biologicals with reported ASP data in the CY 2010 claims data may be too high (74 FR 35328). We stated that a middle ground of approximately one-third to one-half of the total pharmacy overhead cost currently associated with

coded packaged drugs and biologicals in the CY 2008 claims data would represent the most accurate redistribution of pharmacy overhead cost. We included a discussion of indirect overhead costs, such as administrative and general costs, capital costs, staff benefits, and other facility costs that do not vary across drugs, and direct overhead costs, including staff, supplies, and equipment that are directly attributable only to the storage, handling, preparation, and distribution of drugs and biologicals and which do vary, sometimes considerably, depending upon the drug being furnished. We presented analyses that modeled the redistribution of overhead costs in the packaged drugs to all drugs and biologicals based on overhead relative weights derived from industry and from MedPAC's recommended overhead relative weights and by assigning each drug, both packaged and separately paid, to a category of overhead complexity. Analyses relying on both sets of relative weights suggested that indirect costs are a sizable component of the overhead costs associated with all drugs and biologicals (74 FR 60505 to 60508).

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

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

In the CY 2010 OPPS final rule with comment period, we adopted a transitional payment rate of ASP+4 percent based on a pharmacy overhead adjustment methodology for CY 2010 that redistributed $200 million from packaged drug cost to separately payable drug cost. This $200 million included the proposed $150 million redistribution from the pharmacy overhead cost of coded packaged drugs and biologicals for which an ASP is reported and an additional $50 million dollars from the total uncoded drug and biological cost to separately payable drugs and biologicals as a conservative estimate of the pharmacy overhead cost of uncoded packaged drugs and biologicals that should be appropriately associated with the cost of separately payable drugs and biologicals (74 FR 60517). We noted that our final CY 2010 payment policy for separately payable drugs and biologicals at ASP+4 percent fell within the range of ASP–3 percent, that would have resulted from no pharmacy overhead cost redistribution from packaged to separately payable drugs and biologicals, to ASP+7 percent, that would have resulted from redistribution of pharmacy overhead cost based on expansive assumptions about the nature of uncoded packaged drug and biological cost. We acknowledged that, to some unknown extent, there are pharmacy overhead costs being attributed to the items and services reported under the pharmacy revenue code without HCPCS codes that are likely pharmacy overhead for separately payable drugs. We redistributed $50 million in uncoded packaged drug cost and stated that we could not know the amount of overhead associated with these drugs without making significant further assumptions about the amount of pharmacy overhead cost associated with the drugs and biologicals captured by these uncoded packaged drug costs. We finalized a policy of redistributing pharmacy overhead cost from some drugs and biologicals to other drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals in our claims data (no redistribution of cost would occur from other services to drugs and biologicals or vice versa).

b. Payment Policy

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

However, for the CY 2010 OPPS, we revised the standard methodology to include an adjustment for pharmacy

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

For the CY 2011 OPPS/ASC proposed rule, using our standard methodology for determining the total cost of separately payable drugs in our CY 2009 claims data and comparing these costs to the ASP dollars (April 2010 ASP quarterly payment rates multiplied by units for the separately payable drugs and biologicals in the claims data) for the same drugs, we determined that the total payment for separately payable drugs (status indicators "K" and "G"), including acquisition and pharmacy overhead costs, was ASP+0 percent, which also would be the ASP-based payment rate under the standard methodology that we established in CY 2006 (75 FR 46275). Additionally, we determined that the total aggregate cost for packaged drugs with a HCPCS code for which manufacturers report ASP data (status indicator "N"), including acquisition and pharmacy overhead costs, was equivalent to ASP+283 percent. Finally, we determined that the total cost for both packaged drugs with a HCPCS code and separately payable drugs (status indicators "N," "K," and "G") for which we also have ASP data, including acquisition and pharmacy overhead costs, was ASP+14 percent. Table 25 in the proposed rule displayed our findings with regard to the percentage of ASP in comparison to the cost for packaged coded drugs and for separately payable coded drugs before application of the overhead adjustment methodology.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46276), we stated that we believed that the combined payment for average acquisition and pharmacy overhead costs under our standard methodology may understate the cost of separately payable drugs and biologicals and related pharmacy overhead for those drugs and biologicals. Specifically, we stated that we believed payment at ASP+0 percent for such costs may not be sufficient. We also acknowledged that ASP +283 percent may overstate the combined acquisition and pharmacy overhead cost of packaged drugs and biologicals. In the CY 2011 OPPS/ASC proposed rule (75 FR 46276 through 46279), for CY 2011, we proposed to continue our CY 2010 pharmacy overhead adjustment methodology (74 FR 60500 through 60512). We proposed to redistribute $150 million from the pharmacy overhead cost of coded packaged drugs and biologicals with reported ASP data and to redistribute $50 million from the cost of uncoded packaged drugs and biologicals without an ASP, for a total redistribution of $200 million in drug cost from the cost of coded and uncoded packaged drugs to the cost of separately payable drugs, as we did for the CY 2010 final rule.

We estimated the overhead cost for coded packaged drugs to be $438 million ($593 million in total cost for coded packaged drugs and biologicals with a reported ASP less $155 million in total ASP dollars for coded packaged drugs and biologicals with a reported ASP). Similar to the CY 2010 proposal, we proposed for CY 2011 that any redistribution of pharmacy overhead cost would occur only among drugs and biologicals in our claims data, that no redistribution of cost would occur from other services to drugs and biologicals or vice versa. We continued to believe that redistributing $200 million from packaged to separately payable drugs and biologicals was an appropriate redistribution of pharmacy overhead costs to address any charge compression in the standard methodology. This would have resulted in a proposed CY 2011 payment rate for separately payable drugs and biologicals of ASP+6 percent. We emphasized that we proposed a pharmacy overhead adjustment methodology based on a redistribution of overhead cost and that our proposal for payment at ASP+6 percent was a coincidental outcome of the proposed methodology to redistribute $200 million from packaged drugs to separately payable drugs. We did not propose payment of ASP+6 percent for separately payable drugs as an alternative to payment of average acquisition costs based on a survey under section 1833(t)(14)(A)(iii)(I) of the Act. We indicated that we continue to believe that the ASP information collected under section 1847A(b)(1)(A) of the Act and our hospital claims data is a suitable proxy for the acquisition cost data. For a full explanation of our rationale for using ASP data and our hospital claims data as a suitable proxy for acquisition cost data, we refer readers to the CY 2010 OPPS/ASC final rule with comment period (74 FR 60515). We further noted that, in past years, the proposed ASP+X amount decreased by at least 1 percentage point when we updated the ASP data, claims data, and cost report data between the proposed rule and the final rule with comment period, from ASP+5 to ASP+4 for example. Therefore, we stated that it was possible that the proposed methodology would result in an ASP+X amount that is different from ASP+6.

As indicated in Table 25 of the proposed rule, if we had proposed to establish payment for separately payable drugs and biologicals under the standard methodology established in CY 2006 without applying a pharmacy overhead adjustment, we would have proposed to pay for separately payable drugs and biologicals at ASP+0 percent. However, because we were concerned about underpaying separately payable drugs and biologicals, we stated our belief that a pharmacy overhead adjustment using a redistribution methodology for determining the amount of payment for drugs and biologicals as we did for CY 2010 was appropriate. We believed the observed ASP+0 percent reflected some amount of charge compression and variability attributable to choice of a packaging threshold.

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

We generally received positive comments on our CY 2010 proposal to redistribute $150 million of drug cost

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

We explain below our rationale for why we did not propose to redistribute more cost from uncoded packaged drugs. Conversations with stakeholders and hospitals over the past year suggest that hospitals do not always report HCPCS codes for drugs for a variety of reasons, including an internal practice not to code for packaged drugs, building the cost of the drugs into the associated procedure charge, lack of an HCPCS code for some drugs and biologicals, and purchased vendor billing software functionality that removes codes. A key premise of our pharmacy overhead adjustment redistribution methodology was our assessment of the amount of drug cost in the claims data above aggregate ASP available as "overhead" for redistribution. Knowing the specific HCPCS codes for packaged drugs and their associated ASP allows us to assess the differential between aggregate ASP and claim cost for packaged drugs and to assess the intensity of pharmacy overhead associated with these drugs. The inability to know which drugs are captured by uncoded drug charges on a claim is challenging because we cannot know what is being charged or what the overhead complexity might be. Further, we understand that there is wide variation in how hospitals set charges for items and services in their chargemasters, sometimes charging separately for overhead (for example, paper cups, gloves, transportation, staff consultations) and sometimes including charges for those supplies in the charge for drugs. Therefore, we cannot be certain that the amount of uncoded pharmacy overhead cost is as high as the public has suggested or that hospitals mark up these uncoded drugs and biologicals in the same way as packaged drugs and biologicals with HCPCS codes.

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

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

data to separately payable drugs and biologicals and redistributing $50 million in drug cost from uncoded packaged drugs and biologicals to separately payable drugs and biologicals as a conservative estimate of potential overhead cost appearing in uncoded packaged drugs that should have been associated with separately payable drugs and biologicals.

We have indicated that the basis for our CY 2011 proposal to redistribute $150 million dollars from packaged coded drugs and biologicals to separately payable drugs and biologicals as a pharmacy overhead adjustment was the same as our CY 2010 final policy. The CY 2010 final policy was based on our assessment that between one-third and one-half of the overhead cost in coded packaged drugs could be attributable to charge compression due to our cost estimation methodology and our choice of a packaging threshold. We continue to believe that a precise amount of drug cost attributable to charge compression cannot be known, but that $150 million is an appropriate adjustment. We stated in the CY 2011 OPS/ASC proposed rule that the CY 2011 proposal to redistribute $150 million fell within the approximate one-third to one-half range established in CY 2010 OPPS/ASC final rule with updated CY 2009 claim and cost report data, and that we anticipated that the $150 million would continue to roughly approximate one-third to one-half or thereabouts of overhead cost in the coded packaged drugs with updated ASP data, and claim and cost report data for the final rule. In order to redistribute the $150 million in pharmacy overhead from packaged costs of drugs and biologicals for which a HCPCS code was reported, we reduced the costs attributable to these items and services by multiplying the costs derived from the revenue center charges for packaged HCPCs codes by 0.75 (a 25-percent reduction).

To redistribute the $50 million in total cost from packaged costs of drugs and biologicals for which no HCPCS code was reported, we reduced the costs attributable to these items and services by multiplying the costs derived from revenue center charges for pharmacy by 0.92 (an 8-percent reduction). We noted in the CY 2011 OPPS/ASC proposed rule (75 FR 46279) that the $50 million in drug overhead cost that we proposed to redistribute from packaged uncoded drugs and biologicals to separately payable drugs and biologicals was 8 percent, comparable to the amount in the CY 2010 OPPS/ASC final rule with comment period. We noted that $50 million as a percent of uncoded drug cost may be close to the 8 percent range, or thereabouts, of uncoded drug and biological cost in the final rule with updated claim and cost data. In addition, although we arrived at a proposed payment rate of ASP+6 percent, we emphasized that the ASP+6 percent amount may change when ASP+X is recalculated using updated ASP data and claims and cost report data for the CY 2011 OPPS/ASC final rule with comment period.

We also note that although it is CMS' longstanding policy under the OPPS to refrain from instructing hospitals on the appropriate revenue code to use to charge for specific services, we continue to encourage hospitals to bill all drugs and biologicals with HCPCS codes, regardless of whether they are separately payable or packaged using appropriate revenue codes. We noted that we make packaging determinations for drugs annually based on cost information reported under HCPCS codes, and the OPPS ratesetting is best served when hospitals report charges for all items and services with HCPCS codes when they are available, whether or not Medicare makes separate payment for the items and services.

The APC Panel also recommended during its February 2010 public meeting that CMS evaluate the impact of changes in its drug payment policy on hospitals (categorized by type and size) of such a reallocation and present this analysis to the APC Panel at its next meeting. In the proposed rule, we indicated that we accepted this recommendation and would present this analysis to the APC Panel at its next meeting. We presented the analysis at the August 2010 APC Panel meeting.

The APC Panel also recommended at its February 2010 public meeting that CMS continue to evaluate the impact of CMS' drugs and biologicals overhead payment policy on hospitals. We accepted this recommendation in the proposed rule. We note that our regulatory impact analysis presented in section XXIII. of the proposed rule and this final rule with comment period include some of the analysis requested in these last two recommendations.

In conclusion, we proposed for CY 2011 to continue our CY 2010 redistribution methodology (74 FR 60500 through 60512). We proposed to redistribute $150 million from the pharmacy overhead cost of coded packaged drugs and biologicals with an ASP and to redistribute $50 million from the cost of uncoded packaged drugs and biologicals, for a total of $200 million from cost in coded and uncoded packaged drugs to separately payable drugs. We proposed to redistribute pharmacy overhead cost among drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals in our claims data (no redistribution of cost would occur from other services to drugs and biologicals or vice versa). The proposed methodology, when applied using April 2010 ASPs, data for claims for services furnished during CY 2009 and processed through the common working file before January 1, 2010, and the most current submitted cost reports as of January 1, 2010, resulted in ASP+6 percent. We further proposed to continue to include the claims data for 340B hospitals in the calculation of payment for drugs and biologicals under the CY 2011 OPPS because excluding data from hospitals that participate in the 340B program from our ASP+X calculation, but paying those hospitals at that derived payment amount, would effectively redistribute payment to drugs or biologicals from payment for other services under the OPPS, and we do not believe this redistribution would be appropriate (74 FR 35332). In addition, we proposed that hospitals that participate in the 340B program continue to be paid the same amounts for separately payable drugs and biologicals as hospitals that do not participate in the 340B program for CY 2011 because commenters have generally opposed differential payment for hospitals based on their 340B participation status. In addition, we proposed to include claims from 340B hospitals in our assessment of average acquisition cost under section 1833(t)(14)(A)(iii) of the Act. We proposed that the estimated payments for separately payable drugs and biologicals be taken into account in the calculation of the weight scaler that would apply to the relative weights for all procedural services (but would not apply to separately payable drugs and biologicals) paid under the OPPS, as required by section 1833(t)(14)(H) of the Act.

Comment: Most commenters supported ASP+6 percent as the appropriate amount of payment to be made for separately paid drugs for CY 2011. Many of those commenters recommended that payment for separately payable drugs and biologicals be made at least at ASP+6 percent. A few commenters expressed concern that CMS' established methodology is arbitrary in nature, in part because CMS does not truly know the amount of overhead to move for the proposed overhead adjustment. A few commenters generally agreed with CMS' proposal to redistribute pharmacy

overhead cost from packaged drugs and biologicals to separately payable drugs and biologicals. However, several commenters expressed concern that, under this methodology, the projected CY 2011 ASP+X amount of ASP+6 percent may decline to ASP+5 percent or ASP+4 percent in the final rule with comment period. The commenters reasserted their belief that payment at less than ASP+6 percent is insufficient for payment for separately payable drugs and biologicals.

Several commenters supported the payment of ASP+6 percent for separately paid drugs and biologicals and the redistribution methodology on a whole, but did not support the proposed redistribution amount of $200 million from packaged drugs and biologicals ($150 million from coded packaged drugs and biologicals and $50 million from uncoded packaged drugs and biologicals). A majority of commenters recommended that CMS increase the amount redistributed from coded and uncoded packaged drugs and biologicals to separately payable drugs and biologicals. A few of these commenters stated that a larger portion of the overhead costs should be reallocated from packaged uncoded packaged drugs and biologicals to separately payable drugs and biologicals, noting that coded and uncoded drugs and biologicals have similar overall charge mark-up and, therefore, warrant a similar redistribution of costs. Several commenters recommended that an equal or close to equal amount of cost should be redistributed from packaged coded and uncoded drug and biological cost to separately payable drugs and biologicals. A few commenters also disagreed with the results of CMS' study on uncoded drugs, stating that pharmacy overhead and services applies to all drugs, including surgical services, and that these pharmacy services and overhead costs are similar to those costs associated with coded packaged drugs. One commenter recommended that CMS continue to monitor and reevaluate the claims data in the upcoming years to determine whether a larger amount of cost should be redistributed from packaged drugs and biologicals to separately payable drugs and biologicals.

The APC Panel, at its August 2010 meeting, recommended that CMS pay for the acquisition and pharmacy overhead costs of all separately payable drugs at no less than ASP+6 percent for CY 2011 (APC Panel Recommendation 21).

Response: We are not convinced by the commenters that we should necessarily pay separately paid drugs and biologicals at ASP+6 percent or higher for CY 2011, regardless of whether such payment amount results from the methodology we proposed to use to set final payment rates for separately paid drugs and biologicals for CY 2011 in this final rule with public comment period. We believe that to pay for separately paid drugs and biologicals at ASP+6 percent for CY 2011 would redistribute more pharmacy overhead than we believe is appropriate because our application of the proposed methodology results in ASP+5 percent for this final rule with comment period. Our analysis in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60505 through 60512) indicated that a redistribution was appropriate to address charge compression. In our modeling for this OPPS/ASC final rule with comment period, the redistribution amount for CY 2011 of $150 million in overhead cost from coded packaged drugs and $50 million in cost from uncoded packaged drugs that we are finalizing for the CY 2011 OPPS, remains within the parameters of roughly one-third to one-half of overhead cost in coded packaged drugs and about 8 percent of drug cost in uncoded packaged drugs that we finalized for CY 2010, and, therefore, we believe that redistribution of these amounts remains appropriate. Also, we were clear in the CY 2011 OPPS/ASC proposed rule that we were proposing to continue the CY 2010 pharmacy overhead adjustment methodology and that the projected result of ASP+6 percent was coincidental (75 FR 46276).

In addition, we disagree that payment at less than ASP+6 percent would be insufficient to adequately pay for the costs of separately paid drugs and biologicals because our review of claims and cost report data provides no evidence that supports that payment at less than ASP+6 percent is insufficient to pay adequately for the costs of separately paid drugs and biologicals. To the contrary, the utilization of drugs and biologicals continues to increase. In addition, we note that payment for pharmacy overhead is not only paid through payment for specifically identified drugs and biologicals, but pharmacy overhead payment also is packaged into payment for the procedure in which the cost of packaged drugs and biologicals is included. When a separately paid drug or biological is furnished during a procedure, pharmacy overhead is being paid both through the ASP+5 percent payment for the separately paid drug and biological and, to some extent, in the payment for the procedure, because the APC payment for any procedure includes the cost of packaged drugs and the overhead cost associated with those packaged drugs and biologicals.

Although several commenters, and the APC Panel at its February 2010 panel meeting, recommended that CMS reallocate a larger portion of the pharmacy overhead costs from packaged drugs to separately payable drugs for CY 2011 under the overhead adjustment methodology, and others have argued that we should redistribute an equal or nearly equal amount of cost from both packaged drugs and biologicals with HCPCS codes and packaged drugs and biologicals without HCPCS codes, for the reasons set forth below and consistent with our rationale outlined in the CY 2010 OPPS/ASC final rule with public comment period (74 FR 60501 through 60512), we do not believe that we should redistribute a higher portion of drug cost from coded packaged drugs and biologicals, nor can we assume that uncoded packaged drugs and biologicals have the same or higher pharmacy overhead costs as coded packaged drugs and biologicals and, therefore, we do not believe that we can treat them comparably for purposes of estimating overhead. With regard to redistributing more from uncoded packaged drugs and biologicals, first, as indicated in the CY 2011 OPPS/ASC proposed rule (75 FR 46277 through 46278), conversations with stakeholders and hospitals over the past year suggest that hospitals do not always report HCPCS codes for drugs for a variety of reasons. A key premise of the pharmacy overhead adjustment redistribution methodology is our assessment of the amount of drug cost in the claims data above aggregate ASP available as "overhead" for redistribution. Knowing the specific HCPCS codes for packaged drugs and their associated ASP allows us to assess the difference between the aggregate ASP and claim cost for packaged drugs and to assess the intensity of pharmacy overhead associated with these drugs. The inability to know which drugs are captured by uncoded drug charges on a claim is challenging because we cannot know the hospitals' charges for the drug, which include overhead costs, or what the overhead complexity may be. Therefore we cannot be certain that the amount of uncoded pharmacy overhead costs is as high as the public has suggested or that hospitals mark up these uncoded drugs and biologicals in the same way as packaged drugs and biologicals with HCPCS codes. Second, we continue to believe that the information presented by presenters at the February 2010 APC Panel meeting is

insufficient to enable us to isolate the portion of the uncoded packaged drug and biological cost that is pharmacy overhead cost. In order to isolate the portion of uncoded packaged drug and biological cost that is pharmacy overhead cost, we believe that we would need more drug specific information reported to us by hospitals, either through more reporting of packaged drugs on claims or through more granular cost centers on the cost report. As indicated in the CY 2011 OPPS/ASC proposed rule we also evaluated claims data in an effort to assess how much uncoded packaged drugs resemble coded packaged drugs (75 FR 46278). We found that most uncoded packaged drug costs appear with surgical services and that most coded packaged drug costs appear with medical services. In light of this information, we are not confident that the drugs captured by uncoded drug costs are the same drugs captured by the coded packaged drug cost. Therefore we do not agree that we can assume that they are the same drugs, with comparable overhead and handling costs. Without being able to calculate an ASP for these drugs and without being able to gauge the magnitude of the overhead complexity associated with these drugs, we do not believe we should assume the same or a greater proportional overhead is appropriate for redistribution. Third, we also do not believe the commenter's assertions that pharmacy services and overhead costs for all uncoded packaged drugs are similar to the costs associated with coded packaged drugs and are a sufficient basis for redistributing equal or close to equal amounts of dollars from uncoded packaged drugs as from coded packaged drugs to separately paid drugs under this overhead adjustment policy. As we have stated elsewhere, we remain committed to using hospital data as reported to us by hospitals to set OPPS payment rates. Therefore, we continue to believe that it would be inappropriate to assume that the costs reported under uncoded pharmacy revenue code lines are for the same drugs and biologicals with the same ASPs, as the costs of packaged drugs and biologicals reported with HCPCS codes. Therefore, for the reasons set forth above, we continue to believe that we should not make broad assumptions that the same overall charge markup exists for both coded and uncoded packaged drugs or that we should redistribute a similar or greater amount of cost from both coded and uncoded packaged cost to separately payable drugs and biologicals.

We also do not agree that our pharmacy overhead adjustment methodology is arbitrary. The basis for the proposed and final pharmacy overhead adjustment methodology is the same as our CY 2010 final policy. The CY 2010 policy for redistributing $150 million from coded packaged drugs and biologicals to separately payable drugs and biologicals was based on our assessments using both industry and MedPAC data (74 FR 60505 through 60507). We believed and continue to believe that between approximately one-third and one-half of the overhead cost in coded packaged drugs could be attributable to charge compression due to our cost estimation methodology and our choice of a packaging threshold. We continue to believe that an amount of packaged drug cost attributable to charge compression cannot be precisely known, but we do not believe we should distribute more than $150 million from coded packaged drugs. The proposed and final CY 2011 policy of redistributing $150 million from coded packaged drugs and biologicals to separately payable drugs and biologicals roughly approximates one-third to one-half of overhead cost in the coded packaged drugs with updated ASP data, and the CY 2009 claims and most current cost report data used in this final rule with comment period.

The proposed and final CY 2011 policy of redistributing $50 million of the total cost of uncoded packaged drugs and biologicals to separately payable drugs and biologicals falls in the approximate 8 percent range of total uncoded drug and biological cost using the CY 2009 claims and most currently available cost report data used in this final rule with comment period. As indicated in the CY 2010 OPPS/ASC final rule with comment period, this is a conservative estimate, as compared to the case of coded packaged drugs and biologicals with an ASP and for which we have a specific pharmacy overhead cost estimate in relationship to their known ASPs. As explained previously in this response we remain unwilling to make sweeping assumptions that uncoded packaged drug and biological cost included a pharmacy overhead amount comparable to those of coded packaged drugs and biologicals with an ASP. We continue to be confident that this conservative estimate of $50 million for redistribution from the cost of uncoded packaged drugs and biologicals to separately payable drugs and biologicals is an appropriate amount in light of our uncertainty about the relationship between ASP and pharmacy overhead costs for the uncoded drugs and biologicals. We also do not believe this policy is arbitrary because we finalized our CY 2010 policy for an overhead adjustment methodology in response to public commenter consensus that this approach was an appropriate avenue for addressing charge compression in the drug and biological payment rates for separately paid drugs. We believe that the consensus among commenters on a redistribution methodology is further evidence that the policy adopted last year and which we are continuing for CY 2011 has a rational basis and is not arbitrary.

After careful consideration of the comments and reassessment of the most current claims data, cost report data and ASP data, for the reasons discussed above, we are finalizing our proposal to continue the CY 2010 pharmacy overhead adjustment methodology as set forth at 74 FR 60500 through 60512. We are redistributing $150 million from the pharmacy overhead cost of coded packaged drugs and biologicals with an ASP and redistributing $50 million from the cost of uncoded packaged drugs and biologicals, for a total redistribution of $200 million from costs for coded and uncoded packaged drugs to separately payable drugs, with the result that we will pay separately paid drugs and biologicals at ASP+5 percent for CY 2011. For the reasons stated above, we also are not accepting the APC Panel's recommendation to pay for acquisition and pharmacy overhead costs of all separately payable drugs at no less than average sales price plus 6 percent for CY 2011.

After applying our longstanding methodology for calculating the total cost of separately payable drugs and biologicals in the claims on which the CY 2011 final rule payment rates are based, compared to the ASP dollars for the same drugs and biologicals and without applying the proposed overhead cost redistribution using updated claims, cost report, and ASP data, we determined that the estimated aggregate cost of separately payable drugs and biologicals (status indicators "K" and "'G"), including acquisition and pharmacy overhead costs, is equivalent to ASP–1 percent (compared to ASP+0 percent in the proposed rule). Therefore, under our standard drug payment methodology, if we did not adopt our proposed redistribution of $200 million, we would pay for separately payable drugs and biologicals at ASP–1 percent for CY 2011, their equivalent average ASP-based payment rate. During our assessment of the final rule data, we also determined that the estimated aggregate cost of coded packaged drugs

and biologicals with an ASP (status indicator "N") including acquisition and pharmacy overhead costs, is equivalent to ASP+296 (compared to ASP+283 in the proposed rule). We found that the estimated aggregate cost for all coded drugs and biologicals (status indicators "N," "K," and "G"), including acquisition and pharmacy overhead costs, is equivalent to ASP+13 percent (compared to ASP+14 in the proposed rule). These values are shown in Table 32 below.

TABLE 32—CY 2011 PROPOSED AND FINAL ASP+X VALUES FOR ALL CODED DRUGS AND BIOLOGICALS WITH AN ASP, CODED PACKAGED DRUGS AND BIOLOGICALS WITH AN ASP, AND SEPARATELY PAYABLE DRUGS AND BIOLOGICALS UNDER THE STANDARD METHODOLOGY

	ASP+X for all coded drugs and biologicals with an ASP	ASP+X for coded packaged drugs and biologicals with an ASP	ASP+X for separately payable drugs and biologicals
CY 2011 Proposed Rule*	ASP+14	ASP+283	ASP+0
CY 2011 Final Rule**	ASP+13	ASP+296	ASP–1

*Based on CY 2011 proposed rule claims data and April 2010 ASPs.
**Based on CY 2011 final rule claims data and July 2010 ASPs.

We continue to believe that the combined payment for average acquisition and pharmacy overhead costs under our standard methodology may understate the cost of separately payable drugs and biologicals and related pharmacy overhead for those drugs and biologicals. Specifically, payment at ASP–1 percent for such costs may not be sufficient to compensate hospitals for payment for both the acquisition cost of separately paid drugs and biologicals and for the associated pharmacy overhead.

In finalizing our proposed overhead adjustment methodology for CY 2011, we observed that, using updated 2009 claims data and ASPs from July 2010, the overhead cost for coded packaged drugs and biologicals is $457 million ($612 million in total cost for coded packaged drugs and biologicals with a reported ASP less $155 million in total ASP dollars as a proxy for acquisition cost for coded packaged drugs and biological with a reported ASP). Table 33 below displays our final findings with regard to the percentage of ASP in comparison to the cost for packaged coded drugs and for separately payable coded drugs before application of the overhead adjustment methodology.

TABLE 33—CY 2011 FINAL RULE DATA: ASP+X CALCULATION UNDER STANDARD METHODOLOGY

	Total ASP dollars for drugs and biologicals in claims data (in millions)*	Total cost of drugs and biologicals in claims data (in millions)**	Ratio of cost to ASP (column C/ column B)	ASP+X percent
Uncoded packaged pharmacy revenue code costs	Unknown	$652	NA	NA
Coded Packaged Drugs and Biologicals with a reported ASP.	$155	612	3.96	ASP+296
Separately Payable Drugs and Biologicals with a reported ASP.	3,334	3,316	0.99	ASP–1
All Coded Drugs and Biologicals with a reported ASP	3,489	3,927	1.13	ASP+13

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

When we redistribute $200 million in overhead cost from packaged coded and uncoded drugs and biologicals to separately payable drugs and biologicals, while keeping the total cost of drugs in the claims data constant, the resulting final ASP+X payment rate for CY 2011 for separately payable drugs and biologicals is ASP+5 percent. In order to redistribute the $150 million in pharmacy overhead from packaged costs of drugs and biologicals for which a HCPCS code was reported, we reduced the costs attributable to these items and services by multiplying the costs derived from the revenue center charges for packaged HCPCs codes by 0.75 (a 25-percent reduction). To redistribute the $50 million in total cost from packaged costs of drugs and biologicals for which no HCPCS code was reported, we reduced the costs attributable to these items and services by multiplying the costs derived from revenue center charges for pharmacy by 0.92 (an 8-percent reduction). We note that this is consistent with our CY 2011 proposal and our CY 2010 final rule policy. Table 34 below displays our final findings after the overhead adjustment methodology is applied.

TABLE 34—CY 2011 PHARMACY OVERHEAD ADJUSTMENT PAYMENT METHODOLOGY: ASP+X CALCULATION

	Total ASP dollars for drugs and biologicals in claims data (in millions)*	Total cost of drugs and biologicals in claims data *after adjustment* (in millions)**	Ratio of cost to ASP (column C/ column B)	ASP+X percent
Uncoded packaged pharmacy revenue code costs	Unknown	$602	NA	NA
Coded Packaged Drugs and Biologicals with a reported ASP.	$155	462	2.98	ASP+198
Separately Payable Drugs and Biologicals with a reported ASP.	3,334	3,516	1.05	ASP+5
All Coded Drugs and Biologicals with a reported ASP	3,489	3,927	1.13	ASP+13

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

** Total cost in the CY 2009 claims data for drugs and biologicals.

In summary, therefore, for the reasons set forth above, we are finalizing our proposal to continue our CY 2010 pharmacy overhead redistribution methodology. For CY 2011, we are redistributing $150 million in overhead costs from coded packaged drugs and $50 million in overhead costs from uncoded packaged drugs to result in $200 million in costs redistributed from packaged coded and uncoded drugs to separately payable drugs for CY 2011. The redistribution amount of $150 million in overhead cost from coded packaged drugs and $50 million in cost from uncoded packaged drugs are within the redistribution parameters established in our CY 2010 final rule with comment period of roughly one-third to one-half of overhead cost in coded packaged drugs and biologicals and approximately 8 percent of drug cost in uncoded packaged drugs and biologicals.

Adoption of this redistribution methodology results in payment for separately paid drugs and biologicals at ASP+5 percent for CY 2011.

Comment: Some commenters stated that section 1833 (t)(14)(A) of the Act requires CMS to pay for separately payable drugs at a rate that is equal to the average acquisition cost for the drug for a year, as determined by the GAO or CMS surveys of hospital acquisition cost. The commenters stated that the most recent survey available is outdated, as it was performed in CY 2004 by the GAO. In absence of hospital acquisition cost data, the commenters urged CMS to pay for separately payable drugs at ASP+6 percent or the rate applicable in the physician's office setting. The commenters stated that CMS has the authority to pay for separately payable drugs at ASP+6 percent under the statute. Many of these commenters suggested that CMS discontinue the use of the standard methodology altogether and use the default payment rate of ASP+6 percent, as is given by Congress in statute.

Response: While the commenters are correct that the statute provides for the use of the methodology described in section 1842(o), section 1847A, or section 1847B of the Act, as the case may be, as calculated and adjusted by the Secretary as necessary, payment under these provisions for a SCOD is required only when the average hospital acquisition cost for the drug for that year (which at the option of the Secretary may vary by hospital group (as defined by the Secretary based on the volume of covered OPD services or other relevant characteristics)), as determined by the Secretary taking into account the hospital acquisition cost survey data under subparagraph (D), are unavailable. We continue to believe that we have established both our hospital claims data and ASP data as an appropriate proxy for average hospital acquisition cost, taking the GAO survey information into account for the base year (70 FR 68641). Many of the drugs and biologicals covered under the OPPS are provided a majority of the time in the hospital setting, and we believe that the ASP information we collect is an adequate proxy for hospital acquisition cost. Further, the commenters have not disputed the accuracy of the total drug and biological cost estimated in our claims data, only the estimated cost of separately payable drugs and biologicals. As we stated in the CY 2006 OPPS final rule, we intend for the quarterly updates of the ASP based payment rates for separately paid drugs and biologicals to function as the surveys of hospital acquisition costs that are required by section 1833(t)(14)(D)(ii) (70 FR 68641). We continue to believe that average sales prices for separately paid drugs and biologicals represent a generally appropriate source of hospital average acquisition cost for drugs and biologicals. Not only are the prices paid by hospitals (which purchase large quantities of drugs and biologicals, often through group purchasers) included in the ASP but also the prices paid by physician groups that furnish much smaller quantities of these drugs and biologicals are included. In addition the prices paid by hospitals that participate in the 340B discount program are not included in the ASP and thus the cost savings to these hospitals is not reflected in the ASP. For this reason, we believe that the ASP is a generous proxy for hospitals' average acquisition cost for separately paid drugs and biologicals. Therefore, we disagree that we are not complying with the statute by not performing a survey and not paying at the physician's office rate. For the reasons explained above, we do not believe that it is appropriate at this time to provide payment at an amount other than average acquisition cost, with a redistribution for pharmacy overhead, based on the drug and biological costs observed in hospital claims data and pricing information observed in ASP data.

Comment: One commenter stated that the statute requires that CMS make payment for SCODs at ASP+6 percent, citing that cost data derived from claims data cannot accurately be said to equal average acquisition cost. The commenter noted that CMS' methodology in using claims data reduced by CCRs to derive proxies for hospital costs is a methodology dependent on assumptions about the relationship between charges and costs and, therefore, does not typify actual hospital costs for drugs and biologicals. These cost data, the commenter argued, therefore cannot equal average acquisition cost for drugs and biologicals.

Response: As we discuss in the response to the previous comment, we believe that ASP is an appropriate proxy for the acquisition cost of drugs. We use

hospital charges and cost report data to estimate the total cost of drugs and biologicals, including both pharmacy overhead costs and the acquisition cost of drugs and biologicals. We believe that our claims data and cost report data provide the best estimate of the national aggregate total cost of drugs and biologicals. We do not believe that this methodology for estimating the total cost of drugs and biologicals, including pharmacy overhead cost, is based on assumptions about costs and charges, but the actual relationship between costs and charges for the same hospital for the same services. We estimate costs from charges submitted on claims for payment, using cost and charge information from cost report data that are certified to be correct by the hospital. We note that we view the ASP data, not the cost data, to be the best proxy for hospital acquisition cost for drugs and biologicals, without pharmacy overhead costs, while the cost of drugs and biologicals that we estimate from claims and cost report data is the only source of the total cost of drugs and biologicals, that includes both pharmacy overhead and acquisition cost.

Comment: MedPAC remained concerned about our policy of setting payment rates for drugs and biologicals as a percentage of ASP because they stated that pharmacy overhead, as a percentage of total costs, vary widely across individual drugs. MedPAC previously had recommended that CMS collect data on hospital's pharmacy overhead costs separately from drug acquisition costs and that these data could be used to create separate payment to hospitals for pharmacy overhead and drug acquisition costs.

Response: While we acknowledge that pharmacy overhead varies by the drug to which it applies, we believe that as long as payment is distributed among hospitals in a manner that, on average, reflects relative costs of drugs and biologicals they furnish, including pharmacy overhead, the goals of the OPPS are met as it is a system of averages. With regard to the comment that CMS should collect data on hospitals' pharmacy overhead costs separately from drug acquisition costs and that these data could be used to create separate payment to hospitals for pharmacy overhead and drug acquisition costs, as we discuss in detail above, we proposed to create HCPCS codes for pharmacy overhead services so that hospitals could charge for these services and provide us a basis for making separate payments for pharmacy overhead. However, hospitals strongly objected and provided convincing arguments that to do so would impose an enormous burden on them and on other payers that would not provide an offsetting benefit. We believe that hospitals would find any option requiring them to identify the cost associated with the overhead component of a drug or biological or a class of drugs or biologicals burdensome and imprecise.

Comment: Several commenters cited methodological concerns about the approach CMS used to calculate the proposed equivalent average ASP-based payment amount for separately payable drugs and biologicals. Specifically, several commenters noted that, for the proposed rule, CMS used ASP data from the fourth quarter of CY 2009, which is the basis for calculating payment rates for drugs and biologicals in the physician's office setting using the ASP methodology effective April 1, 2009, along with hospital claims data from CY 2009 to determine the relative ASP amount for CY 2011 under CMS' proposed payment methodology. The commenters requested that CMS use an alternative ASP file for the final rule calculation of ASP+X to better align ASP data with hospital claims and cost report data. The commenters stated that the CMS methodology, which they stated uses fourth quarter CY 2009 ASP data as a proxy for drug acquisition costs, provides ASPs that are well after the time hospitals would have purchased most of their drugs for administration in CY 2009. As an alternative, the commenters requested that CMS use an earlier ASP file that is more representative of the costs to hospitals when they purchase drugs for the claims year. Specifically, some commenters requested that CMS use the July 1, 2009 ASP file that represents sales from the first quarter of CY 2009 when comparing CY 2009 hospital claims data to ASP data to determine an ASP+X amount. One commenter requested that CMS clarify a statement made in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60516) that CMS would need to offset any increases in the relative ASP amount resulting from the use of a different ASP file with a deflation adjustment for each hospital's CCRs for cost center 5600 "Drugs Charges to Patients" in order to simulate costs from claim charges in the claim year.

One commenter suggested that CMS' standard methodology was inappropriate because it utilizes estimated costs from claims data that was part of the drug ratesetting methodology that the MMA (Pub. L. 108–173) replaced with the requirement for payment for SCODs at average acquisition cost. Another commenter suggested that CMS' estimated cost from claims was not reliable and that CMS discontinue using the standard methodology and substitute the ASPs for these drugs as the starting point for the overhead adjustment methodology. One commenter indicated that it would expect a fixed redistribution amount to increase each year, similar to CMS' inflation of the packaging threshold each year to reflect increases in the price of drugs and biologicals.

Response: For our calculation of the per day costs for drugs and biologicals in this CY 2011 OPPS/ASC final rule with comment period, we use the ASP data from the first quarter of CY 2010 (which is used to calculate payment rates for drugs and biologicals in the physician's office setting for services furnished on and after July 1, 2010) and with updated hospital claims data (that is, claims for services furnished during CY 2009 which were processed through the Common Working File on or before July 1, 2010). Payment rates for HCPCS codes for separately payable drugs and biologicals included in Addenda A and B to this final rule with comment period are based on ASP data from the second quarter of CY 2010 (which is used to calculate payment rates for drugs and biologicals in the physician's office setting for services furnished on and after October 1, 2010).

Since implementing the ASP+X methodology in CY 2006, we have used the most recently available data to establish our relative ASP payment rate for the upcoming year, consistent with our overall policy of updating the OPPS using the most recent claims and cost report data. For this CY 2011 OPPS/ASC final rule with comment period, this results in using July 2010 ASP payment rates (based on first quarter CY 2010 sales), CY 2009 hospital claims data, and the most recently available hospital cost reports. For this final rule with comment period, the majority of cost reports are from CY 2008, with good representation from CY 2009 and some cost report periods from as early as CY 2004. As we have noted in previous years, the relative ASP+X amount is likely to change from the proposed rule to the final rule as a result of updated ASP data, hospital claims data, and updated hospital cost reports. We do not have evidence that we are introducing significant errors into our ASP+X percent calculation by not aligning all pricing and cost data to a single period of time. However, as we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60516), we believe that if we were to use an ASP file from CY 2009, which the

commenters claimed would more accurately represent hospital costs associated with procuring drugs and biologicals for that claims year, we would need to offset any increases in the relative ASP amount resulting from the use of a different ASP file with a deflation adjustment for each hospital's CCR for cost center 5600 "Drugs Charged to Patient" in order to simulate costs from claim charges in the claims year. As discussed in section II.A. 1.c. of this final rule with comment period, we calculated the APC median costs on which the final CY 2011 APC payment rates are based by applying hospital-specific overall ancillary CCRs and hospital-specific departmental CCRs for each hospital for which we had CY 2009 claims data to charges on claims data. These CCRs are calculated from the most recent available hospital cost reports, in most cases, cost reports for CY 2008. If we follow the commenters' suggestion to use the CY 2009 claims data (with estimated cost on claims created by applying a CY 2008 CCR to CY 2009 charges) with a July 2009 ASP file to calculate the ASP+X percent, we would align two but not three of the data time periods for the majority of hospitals: Cost report data for CY 2008, claims data for CY 2009, and ASP data for July 2009. In general, CCRs typically decline over time. Because of this, our estimated cost in the CY 2009 claims data that we use to model this OPPS modestly overestimates actual cost by applying a CY 2008 CCR to CY 2009 charges. Because CCRs decline each year, we expect that, on balance, CY 2009 CCRs will be lower than CY 2008 CCRs. Therefore, our current methodology applies a higher than actual CCR from CY 2008 to the CY 2009 charges on claims.

Therefore, in order to bring all time periods for the various data elements in the calculation (cost report data, claims data, and ASP data) into alignment, we would need to estimate CCR deflation (the differential in charge and cost inflation) for cost center 5600 between CY 2008 and CY 2009 and apply this deflation factor to the CCRs we use to estimate costs from claims for the majority of hospitals. To be precise, we would need to consider making additional assumptions for hospitals with cost reporting periods before CY 2008. We make comparable CCR deflation estimates when we estimate our fixed dollar eligibility threshold for outlier payments described in section II.F. of this final rule with comment period. We base those estimates on an established IPPS methodology for estimating charge and CCR inflation for all hospital inputs, not just drugs and biologicals.

We have evaluated the impact of using dated CCRs in our estimation, and we find that the slightly higher estimated cost created by using a CCR from the year prior to the claim year (CY 2008 instead of CY 2009) generally offsets the increases in prices in a more recent ASP file for sales from first quarter 2010 for this final rule with comment period, and we believe making assumptions about charge or cost inflation specific to drug charges and costs captured in cost center 5600, which we have not yet estimated, has the potential to introduce error into this calculation. Therefore, we are continuing our current policy of using the most recently available claims data, cost report data, and ASP data when performing our ASP+X calculation under the final redistribution methodology in order to set payment rates for separately payable drugs and biologicals.

We disagree with the commenter who believed our standard ASP+X methodology is inappropriate because it utilizes estimated costs from claims data. We believe the commenter is suggesting that Congress does not want the agency to use estimated costs from claims data in any part of our drug ratesetting methodology for SCODs because the drug ratesetting methodology that we used prior to the MMA (which utilized estimated costs from claims) was replaced with the methodology set forth in section 1833(t)(14) of the Act that was created by the MMA. Section 1833(t)(14)(A)(iii) of the Act sets forth the payment methodology for SCODs for years after 2005, and subjects that payment methodology to section 1833(t)(14)(E) of the Act. Under section 1833(t)(14)(E)(i) of the Act, MedPAC was required to submit a report to the Secretary on the adjustment of the APCs for SCODs to take into account overhead and related expenses, such as pharmacy services and handling costs. Further, section 1833(t)(14)(E)(ii) of the Act authorizes the Secretary to adjust the weights for APCs for SCODs to take into account the recommendations contained in the MedPAC report referenced above. In their June 2005 report, MedPAC indicated that charges for drugs and biologicals are based on both acquisition cost and on the cost of overhead and handling. In order to adjust the payment rates to appropriately account for those overhead and handling costs, as is permitted under the statute, it is necessary for us to use estimated costs from claims data because this information is not available from ASP data. Consequently, we disagree with the commenter that our use of the claims data in the standard ratesetting methodology is inappropriate. Moreover, we continue to believe that we have established our hospital claims data and ASP data as an appropriate proxy for average acquisition cost, taking into account the GAO survey information for the base year (70 FR 68641).

In addition, we note that we believe that we are using our estimated cost on claims data in our ASP+X methodology in a very different way than we did prior to the MMA. Prior to the MMA, we used estimated cost on claims data to calculate a median cost estimate for each drug or biological as we do for each APC, and we based payment on that median cost. After the MMA, we have used ASP data and costs estimated from charges on hospital claims as a proxy for both the average hospital acquisition cost and the pharmacy overhead cost to establish a combined payment rate for acquisition cost and pharmacy overhead. Unlike our methodology prior to the MMA, we are using ASP data in our drug payment calculation in addition to aggregate cost data from claims. In addition, unlike our methodology prior to the MMA, we are not estimating individual cost per drug, but aggregating that cost data. By comparing total ASP dollars for separately paid drugs to total estimated cost on claims data for separately paid drugs, we are estimating an average cost of pharmacy overhead and handling associated with the separately paid drugs and biologicals.

For reasons already discussed, we also do not believe it is appropriate to exclude our claims data from our ASP+X calculation by simply applying a $200 million assessment of overhead to total ASP dollars to arrive at an average weighted ASP+X percent payment level as suggested by one commenter. As noted above, in their June 2005 report, MedPAC found that charges for drugs and biologicals are based both on acquisition cost and on the cost of overhead. Estimating an appropriate overhead amount requires using this data, and we continue to believe that this data is accurate.

With regard to inflating the redistribution amount as we do for the drug packaging threshold, as we discuss below, our proposed redistribution amount of $150 million in overhead cost from coded packaged drugs and $50 million in cost from uncoded packaged drugs remained within the parameters of roughly one-third to one-half of overhead cost in coded packaged drugs and approximately 8 percent of drug

cost in uncoded packaged drugs. We will take the commenter's suggestion into consideration for future years.

Comment: A few commenters expressed concern that when CMS applies a single CCR to adjust charges to costs for drugs and biologicals, charge compression leads to misallocation of pharmacy overhead costs associated with high and low cost drugs and biologicals during ratesetting. The commenters noted that hospitals disproportionately mark up their charges for low cost drugs and biologicals to account for pharmacy overhead costs. Therefore, some commenters suggested using the costs of both packaged drugs and separately payable drugs when calculating the equivalent average ASP-based payment amount for separately payable drugs. They argued that this would provide a more accurate ASP-based payment amount for separately payable drugs. As an alternative, the commenters recommended that CMS eliminate the drug packaging threshold and provide separate payment for all Part B drugs under the OPPS at an ASP+X percent amount calculated from the cost for all drugs with HCPCS codes.

Several commenters objected to the inclusion of data from hospitals that receive Federal discounts on drug prices under the 340B program in the ASP calculation for separately payable drugs and biologicals. The commenters pointed out that hospital participation in the 340B program had grown substantially over the past few years, will further increase due to the provisions in the Affordable Care Act; they believed that the costs from these hospitals now constituted a significant proportion of hospital drug costs on CY 2009 OPPS claims. The commenters stated that including 340B hospital claims data when comparing aggregate hospital costs based on claims data to ASP rates contributed to an artificially low equivalent average ASP-based payment rate because ASP data specifically exclude drug sales under the 340B program.

In addition, MedPAC encouraged CMS to exclude data from 340B hospitals from the ratesetting. MedPAC stated that analysis indicates that exclusion of the 340B hospitals would increase CMS' estimates of the cost of separately paid drugs by about 3.5 percent above the estimate obtained when the 340B hospital claims data are included in the ratesetting calculations and that excluding the 340B hospital claims data would result in payment rates for separately paid drugs that more accurately reflect the costs incurred by other hospitals.

One commenter supported the inclusion of claims data for 340B hospitals in the calculation of the ASP+X payment for separately payable drugs and biologicals and equal payment to 340B hospitals for separately payable drugs and biologicals as hospitals that do not participate in the 340B program. The commenter noted that continuing this policy would maintain an important benefit of the 340B program.

Response: In proposing to continue our CY 2010 overhead adjustment methodology for CY 2011, we attempted to address the issue of charge compression by redistributing some portion of the estimated overhead cost in coded packaged drugs ($150 million) and a conservative estimate of overhead cost in the uncoded packaged drug cost ($50 million). Further, we have made several proposals in the past to more precisely identify pharmacy overhead costs and to address charge compression in the pharmacy revenue center, which were not finalized in response to public comments. As we note in our discussion of the MedPAC comment above, for the CY 2006 OPPS, we proposed to establish three distinct Level II HCPCS C-codes and three corresponding APCs for drug handling categories to differentiate overhead costs for drugs and biological (70 FR 42730). In the CY 2008 OPPS/ASC proposed rule (72 FR 42735), we proposed to instruct hospitals to remove the pharmacy overhead charge for both packaged and separately payable drugs and biologicals from the charge for the drug or biological and report the pharmacy overhead charge on an uncoded revenue code line on the claim. We believed that this would provide us with an avenue for collecting pharmacy handling cost data specific to drugs in order to package the overhead costs of these items into the associated procedures, most likely drug administration services. However, we did not finalize this proposal due to strong objection from hospitals. For CY 2009, we proposed to split the "Drugs Charged to Patients" cost center into two cost centers: One for drugs with high pharmacy overhead costs and one for drugs with low pharmacy overhead costs (73 FR 41492). We note that we expected that CCRs from the proposed new cost centers would be available in 2 to 3 years to refine OPPS drug cost estimates by accounting for differential hospital markup practices for drugs with high and low overhead costs. However, we did not finalize any of these proposals due to concerns from the hospital community that these proposals would create an overwhelming burden on hospitals and staff. By proposing to continue our CY 2010 overhead adjustment methodology, we were once again attempting to address the issue of charge compression without requiring any changes to current hospital reporting practices.

It has been our policy since CY 2006 to only use separately payable drugs and biologicals in the calculation of the equivalent average ASP-based payment amount under the OPPS. We do not include packaged drugs and biologicals in this standard analysis because cost data for these items are already accounted for within the APC ratesetting process through the median cost calculation methodology discussed in section II.A.2 of this final rule with comment period. To include the costs of coded packaged drugs and biologicals in both our APC ratesetting process (for associated procedures present on the same claim) and in our ratesetting process to establish an equivalent average ASP-based payment amount for separately payable drugs and biologicals would give these data disproportionate emphasis in the OPPS by skewing our analyses, as the costs of these packaged items would be, in effect, counted twice. Accordingly, we are not adopting the suggestion from commenters that we include all packaged and separately payable drugs and biologicals when establishing an equivalent average ASP-based rate to provide payment for the hospital acquisition and pharmacy handling costs of drugs and biologicals. However, we remind commenters that, because the costs of packaged drugs and biologicals, including their pharmacy overhead costs, are packaged into the payment for the procedures in which they are administered, the OPPS provides payment for both the drugs and the associated pharmacy overhead costs through the applicable procedural APC payments.

Furthermore, we disagree with the commenters who recommended that we should pay separately for all drugs and biologicals with HCPCS codes. We continue to believe that packaging is a fundamental component of a prospective payment system that contributes to important flexibility and efficiency in the delivery of high quality hospital outpatient services. Therefore, we believe it is appropriate to maintain a modest drug packaging threshold that packages the costs of inexpensive drugs into payment for the associated procedures.

With respect to the comment that we should not include data from hospitals that receive discounts on outpatient drug prices under the 340B program in

our estimation of the total cost of separately paid drugs and biologicals and pharmacy overhead, as we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60517), we continue to believe that excluding data from hospitals that participate in the 340B program from our ASP+X calculation, and paying those hospitals at that derived payment amount, would inappropriately redistribute payment to drugs and biologicals from payment for other services under the OPPS. The ASP-equivalent cost of drugs under the OPPS that would be calculated only from claims data for hospitals that do not participate in the 340B program would likely be higher than the cost of all drugs from our aggregate claims from all hospitals. To set drug payment rates for all hospitals based on a subset of hospital cost data, determined only from claims data from hospitals that do not participate in the 340B program would increase the final APC payment weights for drugs in a manner that does not reflect the drug costs of all hospitals, although all hospitals, including 340B hospitals, would be paid at these rates for drugs. Furthermore, as a consequence of the statutory requirement for budget neutrality, increasing the payment weights for drugs by excluding 340B hospital claims would reduce the relative payment weight for other services in a manner that does not reflect the procedural costs of all hospitals relative to the drug costs of all hospitals, thereby distorting the relativity of payment weights for services based on hospital costs. Many commenters on the CY 2009 OPPS/ASC final rule with comment period were generally opposed to differential payment for hospitals based on their 340B participation status, and we do not believe it would be appropriate to exclude claims from this subset of hospitals in the context of a CY 2011 drug and biological payment policy that is based on average acquisition cost and pays all hospitals at the same rate for separately payable drugs and biologicals.

Comment: One commenter expressed concern over the proposed overhead adjustment methodology, stating that "policy packaged" drugs, similar to contrast agents and diagnostic radiopharmaceuticals, are subject to charge compression and, therefore, should not be included in the redistribution of packaged drug costs to avoid a potential underestimation of costs. The commenter further suggested that CMS remove contrast agents from the pool of "policy packaged" drugs that are redistributed to separately payable drugs and instead redistribute more costs from threshold packaged drugs, or those drugs with per day costs less than the packaging threshold that the commenter attested are not subject to charge compression, to arrive at a payment rate of ASP+6 percent.

Another commenter stated that CMS should not reduce the pharmacy overhead costs for radiology procedures with packaged diagnostic radiopharmaceuticals because of their "policy packaged" status and because of special handling costs associated with radiology procedures. The commenter further stated that CMS should consider using ASP data, if available, to benchmark offset amounts in APCs and to account for pharmacy and overhead costs.

A few commenters expressed concern regarding how CMS accounts for radiopharmaceuticals in the overhead adjustment methodology to redistribute pharmacy overhead costs from packaged drugs and biologicals to separately paid drugs and biologicals and requested that CMS provide details on how costs for radiopharmaceuticals are included in the overhead adjustment methodology. The commenters also asked for clarification on how hospitals are to code for radiopharmaceuticals, citing that CMS' statement on not including the cost of radiopharmaceuticals because they are not reported under pharmacy revenue codes or under the pharmacy cost center on the hospital cost report is contradictory to previous statements urging hospitals to report pass-through diagnostic radiopharmaceutical cost under revenue code 0636.

Response: As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60513), we believe that contrast agents are contributing to the overall charge compression for all drugs and biologicals that are the specific target of our redistribution methodology and that, in almost all cases, hospitals capture the costs and charges for pharmacy revenue codes, including contrast agents, in the cost center 5600 "Drugs Charged to Patients." We stated that this is the cost center that we used to estimate costs from charges for the pharmacy revenue codes in our claims data each year. The proposed methodology of redistributing pharmacy overhead cost from packaged drugs and biologicals to separately payable drugs and biologicals was a proposal to address charge compression observed within this specific cost center that captures the vast majority of costs and charges for drugs and biologicals billed on hospital claims. Therefore, as most hospitals billing contrast agents with pharmacy revenue codes are associating the contrast agent costs with the cost center 5600, we believe it is appropriate to redistribute cost from contrast agents to separately payable drugs and biologicals under our final CY 2011 pharmacy overhead cost redistribution methodology.

In response to the commenter's suggestion that the cost from contrast agents should not be included in the pool of packaged redistributed cost because it has been OPPS policy to package payment for all contrast agents since CY 2008 (as discussed in V.B.2.d of this final rule with comment period), as we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60514), the proposed methodology for redistributing pharmacy overhead cost from packaged drugs and biologicals was not only a proposal to address charge compression, but specifically a proposal to address charge compression in light of our adoption of a specific drug packaged threshold, which is $70 for CY 2011. The argument that it would, therefore, be inappropriate to redistribute cost from contrast agents could have merit if there was a sizeable amount of aggregate cost for contrast agents with per day costs greater than the drug packaging threshold of $70. In that case, it could be argued that the compression in cost estimates for expensive contrast agents (those with per day costs greater than the $70 packaging threshold) created by estimating costs for those agents by applying the CCR for the single cost center 5600 to expensive contrast agents' charges would be offset by the overestimation of costs for inexpensive contrast agents (those with per day costs less than the $70 packaging threshold) created by application of the same single CCR to inexpensive contrast agents' charges, assuming that hospitals apply a lower markup to expensive contrast agents and a higher markup to inexpensive contrast agents. If the mix of expensive and inexpensive contrast agents resembled the mix of expensive and inexpensive drugs generally captured in the cost center 5600, the use of a single CCR would accurately estimate total cost of contrast agents in aggregate. Because all contrast agents not receiving pass-through payment are packaged, packaging an accurate aggregate cost estimate for contrast agents could argue against redistributing cost from packaged contrast agents to separately payable drugs and biologicals. However, we have not observed any evidence of this in our CY 2011 final rule claims data.

In conclusion, because contrast agents are billed under pharmacy revenue codes and accounted for in the cost center 5600 and because the per day cost of almost all contrast agents falls under the CY 2010 packaging threshold of $70, we believe the estimated cost of contrast agents (which are packaged drugs with HCPCS codes and ASPs for which we have found the estimated cost to be ASP+296 percent), along with all other packaged drugs billed under pharmacy revenue codes and accounted for in cost center 5600, contain a disproportionate amount of pharmacy overhead cost, and that it is appropriate to include them in our final CY 2011 redistribution methodology as this methodology is targeted to packaged drugs and biologicals accounted for in cost center 5600.

While we believe that contrast agents are commonly billed under pharmacy revenue codes and that hospitals largely account for the cost of contrast agents under the cost center 5600 on their Medicare hospital cost report, we did not observe that hospitals apply the same practice for diagnostic radiopharmaceuticals. After reviewing our claims data, we found that the majority of diagnostic radiopharmaceuticals are billed under revenue code 0343 (Nuclear medicine; Diagnostic Radiopharmaceuticals), which we believe is appropriate. As specified in our revenue code-to-cost center crosswalk, we believe hospitals largely account for the costs and charges associated with revenue code 0343 in a nonstandard cost center for Diagnostic Nuclear medicine or the cost center 4100 "Radiology-Diagnostic." Because the redistribution of pharmacy overhead cost from packaged drugs and biologicals to separately payable drugs and biologicals is intended to specifically address charge compression in the pharmacy cost center, in light of the above information, we excluded the costs of both diagnostic and therapeutic radiopharmaceuticals from our estimate of total drug and biological cost in the claims data from the final CY 2011 redistribution methodology, as we proposed. As a result, the final payment rates for nuclear medicine procedures that incorporate the costs of packaged diagnostic radiopharmaceuticals are not impacted by the final redistribution methodology. With regard to the comment that we should use ASP data to benchmark offset amounts for APCs that require radiopharmaceuticals, we note that we do not collect ASP data on diagnostic radiopharmaceuticals. Moreover, the current process for identifying the cost of a radiopharmaceutical for purposes of offsetting the cost when a radiopharmaceutical with pass through status is furnished is based on the historic costs for the radiopharmaceutical being replaced by the pass-through radiopharmaceutical and therefore represents the complete cost, including overhead costs. We believe that the historic cost of radiopharmaceuticals that were supplied to furnish the nuclear medicine procedure is a more complete and appropriate offset amount than the ASP amount would be, if CMS gathered ASP data for diagnostic radiopharmaceuticals, because the historic cost of the radiopharmaceuticals includes the overhead cost as well as the acquisition cost of the radiopharmaceuticals being replaced by the pass-through radiopharmaceuticals.

With regard to the request for coding advice, we note that we generally require hospitals to follow National Uniform Billing Committee (NUBC) guidance for the choice of an appropriate revenue code that also is appropriate for the hospital's internal accounting processes. As we discuss below, we have encouraged hospitals to consider reporting all drugs in revenue code 0636 (Pharmacy-Extension of 025X; Drugs Requiring Detailed Coding) only to improve HCPCS coding for packaged drugs and biologicals in our claims data to improve the accuracy of our ASP+X calculation. We continue to believe that more complete data from hospitals identifying the specific drugs that were provided during an episode of care will improve payment accuracy for separately payable drugs in the future. However, we believe hospitals should report diagnostic radiopharmaceuticals with the most appropriate revenue code, and we are confident that coding for diagnostic radiopharmaceuticals will occur because of our claims edits for radiolabeled products.

Comment: Several commenters were concerned with statements in the CY 2011 OPPS/ASC proposed rule that all drugs and biologicals with HCPCS codes should be billed under revenue code 0636. These commenters stated that the statements may confuse hospitals and recommended that CMS clarify that the original intent of revenue code 0636 was to capture those drugs for which a health plan requires special tracking, such as for costly cancer drugs. These commenters believed that hospitals should continue to use other revenue code categories along with their respective HCPCS codes, such as revenue codes 025x (Pharmacy) or 062x (Pharmacy-Extension of 025x). In addition, the commenters noted that there are drugs that do not have a specific revenue code, such as aspirin, for which an "unspecified drugs" HCPCS code could be used. One commenter requested that CMS clarify whether it intended that a new revenue code for unspecified drugs should be created and whether these codes should be captured on a different line item on the cost report.

At its August 2010 meeting, the APC Panel recommended that CMS require hospitals to report all drugs with a HCPCS code using revenue code 0636, regardless of payment status (Recommendation 20). Some commenters supported the APC Panel recommendation and requested that CMS require all hospitals to report all drugs with a HCPCS code using revenue code 0636, whether the drug was packaged or paid separately. These commenters indicated that they believed that reporting all drugs with HCPCS codes under revenue code 0636 would not only support better ratesetting for drugs and biologicals but would also support the implementation of section 9008 of the Affordable Care Act. Other commenters asked that CMS require that hospitals report HCPCS codes for all drugs that have them and report HCPCS code J3490 (Unclassified biologics) for all drugs that do not have a HCPCS code that is specific to the drug or biological. The commenters stated that to do so would impose virtually no burden on hospitals, which must already report both HCPCS codes and national drug codes (NDCs) for all drugs they furnish when they bill Medicaid. Although the commenters asked that CMS require mandatory reporting of all drugs using either specific HCPCS codes or J3490, they believed that CMS should leave the choice of the revenue code that must be reported on the line to the discretion of the hospital.

Response: We did not intend to suggest in the proposed rule that all drugs and biologicals with HCPCS codes should be billed under revenue code 0636 solely. We cannot provide the original intent of the creation of revenue code 0636 because the NUBC establishes revenue codes. However, we agree with commenters that drugs and biologicals with HCPCS codes may be appropriately reported in revenue code categories other than revenue code 0636, including, but not limited to, revenue codes 025x and 062x. Therefore, we are not accepting the APC Panel recommendation and the recommendation of some commenters that we require that all drugs and biologicals with HCPCS codes must be

reported with revenue code 0636. We recognize that hospitals may carry the costs of drugs and biologicals in multiple cost centers and that it may not be appropriate to report the cost of all drugs and biologicals in one specified revenue code. Similarly, we are not accepting the recommendation of some commenters that we require that hospitals report all drugs and biologicals using HCPCS codes and report drugs and biologicals that do not have specific HCPCS codes using HCPCS code J3490 for the CY 2011 OPPS. We do not believe that it would be appropriate to impose such a requirement without first proposing it and considering the comments of the public.

However, we continue to believe that OPPS ratesetting is most accurate when hospitals report charges for all items and services that have HCPCS codes using those HCPCS codes, regardless of whether payment for the items and services is packaged. As we state in this final rule with comment period, it is our standard ratesetting methodology to rely on hospital cost report and charge information as it is reported to us through the claims data. We continue to believe that more complete data from hospitals identifying the specific drugs that were provided during an episode of care will improve payment accuracy for separately payable drugs in the future. Therefore, we continue to encourage hospitals to change their reporting practices if they are not already reporting HCPCS codes for all drugs and biologicals furnished, where specific HCPCS codes are available for those drugs and biologicals.

In response to the commenters' request that CMS address the need for a new revenue code for drugs and biologicals without HCPCS codes and whether the costs of these drugs and biologicals should be captured on a different line on the cost report, we do not at this time see a benefit in implementing a new revenue code for drugs and biologicals nor do we see a need to require hospitals to capture these costs on a specified line on the cost report at this time. Neither creation of a new revenue code for drugs nor specifying that hospitals must capture drug and biological costs on a specified line in the cost report are necessary for us to redistribute pharmacy overhead from packaged drugs to separately paid drugs and biologicals and we believe that they would impose unnecessary burden on hospitals without improving payment for drugs and biologicals.

Comment: One commenter requested that CMS release all details pertaining to the study mentioned in the CY 2011 OPPS/ASC proposed rule on uncoded drugs and biologicals.

Response: We make available to the public the claims data we use for purposes of the establishment of the OPPS payment rates so that the public may undertake studies of interest to them. Our Web site includes information about purchasing the "OPPS Limited Data Set," which now includes the additional variables previously available only in the OPPS Identifiable Data Set, including ICD–9–CMS diagnosis codes and revenue code payment amounts. Information on acquiring these data is available on the CMS Web site at: *http://www.cms.gov/hospitalOutpatientPPS.*

In the CY 2011 OPPS/ASC proposed rule (75 FR 46278), we discuss our analysis of uncoded packaged drug and biological cost and our evaluation of the services with which uncoded packaged drug cost appears in the claims data, in an effort to assess how much uncoded drugs resemble coded packaged drugs. We found that most uncoded packaged drug costs appear with surgical services (status indicator "T"), and that most coded packaged drug costs appear with medical services (status indicators "S", "V", "X"). We stated that, in light of this information, we were not confident that the drugs captured by uncoded drug cost are the same drugs captured by coded packaged drug cost. Therefore, we stated that we did not believe we could assume that they are the same drugs, with comparable overhead and handling costs. We continue to believe redistributing $150 million in coded packaged drug cost and $50 million in uncoded packaged drug cost to separately payable drugs is a fair and sufficient amount for adequate payment for separately payable drugs. Because we cannot be certain that we know what portion of the uncoded drugs and biologicals cost is acquisition cost versus pharmacy overhead costs, we have no compelling reason to redistribute a greater amount of drug cost. Without being able to calculate an ASP for these drugs and biologcials and without being able to gauge the magnitude of overhead complexity associated with these drugs and biologicals, we do not believe that we should assume that the same amount of proportional overhead should be redistributed.

Comment: One commenter recommended that CMS implement a payment rate floor of ASP+4 percent if the current methodology is not discontinued.

Response: We do not see a need to implement a payment rate floor of ASP+4 percent. We believe that the CY 2011 OPPS policy that combines payment for average acquisition and pharmacy overhead costs under our standard methodology appropriately captures the cost of separately payable drugs and biologicals and related pharmacy overhead for those drugs and biologicals and, therefore, a payment floor is unnecessary. We proposed and are finalizaing an overhead adjustment methodology to pay for separately payable drugs and biologicals at what we believed was an appropriate ASP+X payment amount. We continue to believe that this methodology is appropriate for CY 2011, as explained elsewhere in this preamble. In addition, we disagree with commenters that a payment floor of specifically ASP+4 percent should be implemented, as there is no data or evidence to support that ASP+4 percent is an appropriate amount to be used as a payment floor for the payment rate for separately paid drugs and biologicals.

Comment: One commenter recommended that CMS pay for all separately payable drugs and biologicals at ASP+14 percent or at the cost for all coded drugs and biologicals as presented in the CY 2011 OPPS/ASC proposed rule.

Response: We disagree with the commenter that all separately payable drugs and biologicals should be paid at ASP+14 percent. The commenter makes this recommendation, noting that ASP+14 percent was the cost we found in the proposed rule data for packaged and separately payable drugs and biologicals that have HCPCs codes. Paying for separately payable drugs at this payment rate would deviate from our proposed and final overhead adjustment methodology and our standard methodology, as it would pay for separately payable drugs and biologicals at the cost for all coded drugs. As we noted above, we do not include packaged drugs and biologicals in the standard analysis because cost data for these items are already accounted for within the APC ratesetting process through the median cost calculation methodology discussed in section IIA.2 of this final rule with comment period. To include the costs of coded packaged drugs and biologicals in both our APC ratesetting process (for associated procedures present on the same claim) and in our ratesetting process to establish an equivalent average ASP-based payment amount for separately payable drugs and biologicals would give these data disproportionate emphasis in the OPPS by skewing our analyses, as the costs of these packaged items would be, in effect, counted twice.

Therefore, we find no basis to pay for separately payable drugs and biologicals at ASP+14 percent under our overhead adjustment methodology, which redistributes $200 million in cost from coded and uncoded packaged drugs and biologicals to separately payable drugs and biologicals. We continue to believe that redistributing $200 million under our overhead adjustment methodology is appropriate for CY 2011. Therefore, for CY 2011, we are finalizing our proposal to continue our CY 2010 overhead adjustment methodology. This methodology results in a redistribution of $200 million in cost from packaged drugs and biologicals to separately payable biologicals, resulting in a payment rate of ASP+5 percent for CY 2011.

After consideration of the public comments we received, we are finalizing our proposal, without modification, to continue our CY 2010 redistribution methodology. Under this methodology, we will redistribute $150 million from the pharmacy overhead cost of coded packaged drugs and biologicals with an ASP and will redistribute $50 million from the cost of uncoded packaged drugs and biologicals for a total of $200 million to be redistributed from cost in coded and uncoded packaged drugs to payment for separately payable drugs for CY 2011. We will redistribute pharmacy overhead cost among drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals in our claims data (no redistribution of cost would occur from other services to drugs and biologicals or vice versa). The result of the proposed methodology when applied using July 2010 ASP, data for claims for services furnished during CY 2009 and processed through the Common Working File before January 1, 2010, and the most recent submitted cost reports as of January 1, 2010, is a final payment rate for separately paid drugs and biologicals of ASP+5 percent for CY 2011. We will continue to include the claims data for 340B hospital in our assessment of the total cost of drugs and biologicals that we use to calculate the amount above ASP that represents pharmacy overhead under the CY 2011 OPPS for the reasons stated above. In addition, we are finalizing our proposal to continue to pay hospitals that participate in the 340B program at the same rate for separately payable drugs and biologicals as we will pay hospitals that do not participate in the 340B programs for CY 2011 because we are continuing to include the cost of drugs and biologicals furnished by 340B hospitals in our methodology. In addition, we will include claims from 340B hospitals in our calculation of the final payment rate for separately paid drugs and biologicals. The estimated payment for separately payable drugs and biologicals is taken into account in the calculation of the weight scaler that will apply to the relative weights for all procedures services (but will not apply to separately payable drugs and biologicals) paid under the OPPS, as required by section 1833(t)(14)(H) of the Act.

We note that we continue to pursue the most appropriate methodology for establishing payment for drugs and biologicals under the OPPS and that we will continue to evaluate the appropriateness of this methodology when we establish each year's payment for drugs and biologicals under the OPPS.

We note that separately payable drug and biological payment rates listed in Addenda A and B to this final rule with comment period, which illustrate the final CY 2011 payment of ASP+5 percent for separately payable nonpass-through drugs and nonimplantable biologicals and ASP+6 percent for pass-through drugs and biologicals, reflect either ASP information that is the basis for calculating payment rates for drugs and biologicals in the physician's office setting effective October 1, 2010, or mean unit cost from CY 2009 claims data and updated cost report information available for this final rule with comment period. In general, these published payment rates are not reflective of actual January 2011 payment rates. This is because payment rates for drugs and biologicals with ASP information for January 2011 will be determined through the standard quarterly process where ASP data submitted by manufacturers for the third quarter of 2010 (July 1, 2010 through September 30, 2010) are used to set the payment rates that are released for the quarter beginning in January 2011 near the end of December 2010. In addition, payment rates for drugs and biologicals in Addendum A and B to this final rule with comment period for which there was no ASP information available for October 2010 are based on mean unit cost in the available CY 2009 claims data. If ASP information becomes available for payment for the quarter beginning in January 2011, we will price payment for these drugs and biologicals based on their newly available ASP information. Finally, there may be drugs and biologicals that have ASP information available for this final rule with comment period (reflecting October 2010 ASP data) that do not have ASP information available for the quarter beginning in January 2011. These drugs and biologicals will then be paid based on mean unit cost data derived from CY 2009 hospital claims. Therefore, the payment rates listed in Addenda A and B to this final rule with comment period are not for January 2011 payment purposes and are only illustrative of the CY 2011 OPPS payment methodology using the most recently available information at the time of issuance of this final rule with comment period.

c. Payment Policy for Therapeutic Radiopharmaceuticals

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

In CY 2008, we packaged payment for all diagnostic radiopharmaceuticals and we proposed and finalized a methodology to provide prospective payment for therapeutic radiopharmaceuticals (defined as those Level II HCPCS codes that include the term "therapeutic" along with a radiopharmaceutical in their long code descriptors) using mean costs derived from the CY 2006 claims data, where the costs were determined using our

standard methodology of applying hospital-specific departmental CCRs to radiopharmaceutical charges, defaulting to hospital-specific overall CCRs only if appropriate departmental CCRs were unavailable (72 FR 66772). Following issuance of the CY 2009 OPPS/ASC proposed rule, section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) amended section 1833(t)(16)(C) of the Act, as amended by section 106(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173), to further extend the payment period for therapeutic radiopharmaceuticals based on hospital's charges adjusted to cost through December 31, 2009. Therefore, for CY 2009, we finalized a policy to continue to pay hospitals for therapeutic radiopharmaceuticals at charges adjusted to cost through the end of CY 2009.

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

We believe that the rationale outlined in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60524 through 60525) continues to be appropriate for nonpass-through separately payable therapeutic radiopharmaceuticals in CY 2011. Therefore, in the CY 2011 OPPS/ASC proposed rule (75 FR 46280), we proposed to continue to pay all nonpass-through, separately payable therapeutic radiopharmaceuticals under the ASP+X payment level established using the proposed pharmacy overhead adjustment based on a redistribution methodology to set payment for separately payable drugs and biologicals (as discussed in section V.B.3.b.) based on ASP information, if available, for a "patient ready" dose and updated on a quarterly basis for products for which manufacturers report ASP data. For a full discussion of how a "patient ready" dose is defined, we refer readers to the CY 2010 OPPS/ASC final rule with comment period, 74 FR 60520 through 60521. We also proposed to rely on CY 2009 mean unit cost data derived from hospital claims data for payment rates for therapeutic radiopharmaceuticals for which ASP data are unavailable and to update the payment rates for separately payable therapeutic radiopharmaceuticals, according to our usual process for updating the payment rates for separately payable drugs and biologicals, on a quarterly basis if updated ASP information is available.

Comment: A majority of commenters supported CMS' proposal to continue to pay for separately payable therapeutic radiopharmaceuticals under the ASP+X payment level established using the proposed pharmacy overhead adjustment based on a redistribution methodology to set payment for separately payable drugs and biologicals based on ASP information, if available, for a "patient ready" dose and updated on a quarterly basis for products for which manufacturers report ASP data. One commenter supported the proposed payment rate for nonpass-through separately payable drugs, biologicals, and therapeutic radiopharmaceuticals at ASP+6 percent.

Several commenters disagreed with CMS' proposal to rely on CY 2009 mean unit cost data derived from hospital claims data for payment rates for therapeutic radiopharmaceuticals for which ASP data are unavailable. The commenters suggested that CMS instead use hospital's charges adjusted to cost when ASP data are unavailable for nonpass-through separately payable therapeutic radiopharmaceuticals. Some commenters also recommended that CMS provide cost-based payment to hospitals when ASP is not available. A few commenters further noted that CMS should require all manufacturers of therapeutic radiopharmaceuticals to submit ASP data for all therapeutic radiopharmaceuticals currently paid under the OPPS.

Response: We appreciate the commenters' support. We continue to believe that providing payment for therapeutic radiopharmaceuticals based on ASP or mean unit cost if ASP information is not available would provide appropriate payment for these products. When ASP data are not available, we believe that paying for therapeutic radiopharmaceuticals using mean unit cost would appropriately pay for the average hospital acquisition and associated handling costs of nonpass-through separately payable therapeutic radiopharmaceuticals. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60523), although using mean unit cost for payment for therapeutic radiopharmaceuticals when ASP data are not available is not the usual OPPS process (that relies on alternative data source, such as WAC or AWP, when ASP information is temporarily unavailable, prior to defaulting to the mean unit cost from hospital claims data), we continue to believe that WAC or AWP is not an appropriate proxy to provide OPPS payment for average therapeutic radiopharmaceutical acquisition cost and associated handling costs when manufacturers are not required to submit ASP data. In addition, we do not believe that we should provide payment at charges reduced to cost or reasonable cost when ASP data is not available. We have stated previously, in the CY 2008 OPPS/ASC final rule with comment period, that we continue to believe that payment on a claim-specific basis is not consistent with the payment of items and services on a prospective basis under the OPPS and may lead to extremely high or low payments to hospitals for radiopharmaceuticals, even when those products would be expected to have relatively predictable and consistent acquisition and handling costs across individual clinical cases and hospitals. For CY 2011, Medicare pays for only a few outpatient services at reasonable cost, which are not paid under the OPPS but through cost report settlement. These include but are not limited to corneal tissue acquisition, and influenza vaccines. Corneal tissue acquisition and influenza vaccines are paid at reasonable cost because the input costs for future years are hugely unpredictable and to set a prospective payment rate for them may result in payment that is so deficient that hospitals would not be able to provide the services and the general public could be denied the benefits. In particular, it is not possible to forecast with confidence what the cost of influenza vaccine would be a year in advance. In contrast, however, the input costs of therapeutic radiopharmaceuticals are not hugely unpredictable. Therefore, we do not believe that therapeutic radiopharmaceuticals should be paid in the same manner as outpatient services paid at reasonable cost. We continue to believe that when ASP data are unavailable for therapeutic radiopharmaceuticals, payment based upon mean-unit cost is an appropriate proxy for hospital's acquisition and handling data.

We disagree with the commenters who suggested that CMS require all manufacturers of therapeutic

radiopharmaceuticals to submit ASP data for all therapeutic radiopharmaceuticals currently paid under the OPPS. We continue to believe that requiring ASP data for all therapeutic radiopharmaceuticals currently paid under the OPPS would potentially be burdensome for manufacturers. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60524), the challenges involved in reporting ASP for a radiopharmaceutical, given the variety of manufacturing processes, are significant in some cases and, therefore, payment based on mean unit cost from historical hospital claims data offers the best proxy for average hospital acquisition cost and associated handling costs for a radiopharmaceutical in the absence of ASP. We continue to believe that we should allow, but not require, manufacturers to submit ASP information for therapeutic radiopharmaceuticals. If ASP information is unavailable for a therapeutic radiopharmaceutical, meaning that a manufacturer is not willing or not able to submit ASP information, we will provide payment based on the mean unit cost of the product that is applicable to payment rates for the year the nonpass-through therapeutic radiopharmaceutical is administered.

Comment: One commenter stated that while it supported paying separately payable therapeutic radiopharmaceuticals under the ASP+X payment methodology established in the CY 2011 proposed rule, it believed that payment for radiopharmaceuticals should be made at a higher level than other drugs and biologicals because of the unique pharmacy handling and overhead costs association with radiopharmaceuticals. The commenter therefore recommended that CMS pay for radiopharmaceuticals at a payment rate of at least ASP+10 percent while continuing to develop detailed data on the overhead and handling costs associated with radiopharmaceuticals.

Response: We continue to believe that paying for therapeutic radiopharmaceuticals under the ASP+X payment amount established for separately payable drugs and biologicals, established at ASP+5 percent for CY 2011, is the most appropriate proxy for acquisition and pharmacy overhead and handling costs for separately payable therapeutic radiopharmaceuticals. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60522), we established our interpretation of "patient-ready" for purposes of the OPPS to mean the ASP, reported in terms that reflect the applicable HCPCS code descriptor, for all component materials of the radiopharmaceutical and any additional processing, including radiolabeling, that is reflected in the price the manufacturer charges for the radiopharmaceutical so long as the fees paid for such additional processing meet the "bona fide service fee" test under the regulations implementing section 1847A of the Act. We explicitly noted that because radiopharmaceuticals uniquely require radiolabeling of their component materials, we believe that, for purposes of OPPS ASP reporting, radiolabeling could constitute a bona fide service on behalf of the manufacturer and the fees could meet the "bona fide service fee" test. Given our position on radiolabeling, we similarly believe that significant processing costs associated with handling radiopharmaceuticals may be reflected in the prices used to calculate the manufacturer's ASP data for OPPS purposes. Therefore, the combined single payment for nonpass-through separately payable therapeutic radiopharmaceutical acquisition and overhead costs embodied in the ASP+5 percent payment rate for CY 2011 would address any other processing after the sale by the manufacturer, and we continue to believe this payment is sufficient for these additional handing costs borne by the hospital. Under this interpretation of "patient-ready" dose, we do not believe that making an additional payment for more intensive handling costs is necessary.

Comment: One commenter indicated that CMS did not publish a payment rate that reflected the most recently available price for HCPCS code A9545 (Iodine I-131 tositumomab, therapeutic, per treatment dose) in the CY 2011 OPPS/ASC proposed rule. The commenter noted that the payment rate published in the proposed rule reflected second quarter ASP instead of the third quarter ASP. The commenter suggested that CMS ensure that the CY 2011 final rule payment rate reflects the most current ASP data for HCPCS code A9545.

Response: The proposed payment rate published in Addenda A and B to the CY 2011 OPPS/ASC proposed rule for HCPCS code A9545 reflected second quarter ASP payment rates as of April 1, 2010. We disagree with the commenter's assertion that we should have published the ASP released for the third quarter of 2010 or ASP payment rates as of July 1, 2010. We do not include payment rates in Addenda A and B reflecting third quarter ASP payment rates (July payment rates) for proposed rules because ASP pricing information for the third quarter of 2010 was not available, at the time of the development of the proposed rule, As we state above, separately payable drug and biological payment rates listed in Addenda A and B of this final rule with comment period, which illustrate the final CY 2011 payment of ASP+5 percent for separately payable nonpass-through drugs, reflect either ASP information effective October 1, 2010, or mean unit cost from CY 2009 claims data and updated cost report information available for this final rule with comment period. In general, these published payment rates are not reflective of actual January 2011 payment rates. This is because payment rates for drugs and biologicals with ASP information for January 2011 will be determined through the standard quarterly process where ASP data submitted by manufacturers for the third quarter of 2010 (July 1, 2010 through September 30, 2010) are used to set the payment rates that are released for the quarter beginning in January 2011 near the end of December 2010. The payment rate for HCPCS code A9545 is contained in Addenda A and B of this final rule with comment period.

After consideration of the public comments we received, we are finalizing our proposal, without modification, to continue to pay all nonpass-through, separately payable therapeutic radiopharmaceuticals under the ASP+X payment level established using the pharmacy overhead adjustment based on a redistribution methodology to set payment for separately payable drugs and biologicals (as discussed in section V.B.3.b. of this final rule with comment period) based on ASP information, if available, for a "patient ready" dose and updated on a quarterly basis for products for which manufacturers report ASP data. For CY 2011, nonpass-through separately payable therapeutic radiopharmaceuticals will be paid at ASP+5 percent under the ASP+X payment methodology for nonpass-through separately payable drugs and biologicals. We will base nonpass-through, separately payable therapeutic radiopharmaceutical payment rates on mean unit cost derived from CY 2009 claims data when ASP pricing is not available. The final CY 2011 payment rates for nonpass-through separately payable therapeutic radiopharmaceuticals are included in Addenda A and B to this final rule with comment period.

4. Payment for Blood Clotting Factors

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46280), we proposed to pay for blood clotting factors at ASP+6 percent, consistent with our proposed payment policy for other nonpass-through separately payable drugs and biologicals, and to continue our policy for payment of the furnishing fee using an updated amount. The furnishing fee update is based on the percentage increase in the Consumer Price Index (CPI) for medical care for the 12-month period ending with June of the previous year. Because the Bureau of Labor Statistics releases the applicable CPI data after the MPFS and OPPS/ASC proposed rules are published, we are not able to include the actual updated furnishing fee in the proposed rules. Therefore, in accordance with our policy, as finalized in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66765), we proposed to announce the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculated based on that figure through applicable program instructions and posting on the CMS Web site at: *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/*.

Comment: A few commenters supported CMS' proposal to continue to apply the furnishing fee for blood clotting factors provided in the OPD. One commenter stated that the furnishing fee helps ensure patient access to blood clotting factors by increasing the payment rate for these items. Other commenters supported payment for blood clotting factors at no less than ASP+6 percent for CY 2011 and stated that payment at less than ASP+6 percent for all drugs and biologicals, especially blood clotting factors and all drugs and biologicals, is inappropriate. Finally, one commenter supported the payment of blood clotting factors at the same rate that applies to other nonpass-through separately payable drugs and biologicals in the OPD.

Response: We appreciate the commenters' support. We continue to believe that applying the furnishing fee for blood clotting factors is appropriate for CY 2011. However, we see no compelling reason to provide payment for blood clotting factors under a different methodology for OPPS purposes at this time. For CY 2011, under this final rule with comment period, we will pay for blood clotting factors under the same methodology as other separately payable drugs and biologicals under the OPPS and to continue paying an updated furnishing fee. For the reasons we discuss in section V.B.3. of this final rule with comment period, we believe that the payment rate of ASP+5 percent is appropriate payment for the acquisition cost and pharmacy overhead related to drugs and biologicals that are not packaged, which includes blood clotting factors. In addition, because we recognize that there is additional work involved in acquiring the product, that is neither acquisition cost nor pharmacy overhead, we believe that it continues to be appropriate to pay a furnishing fee for blood clotting factors under the OPPS as is done in the physician's office setting and the inpatient hospital setting.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to provide payment for blood clotting factors under the same methodology as other separately payable drugs and biologicals under the OPPS and to continue paying an updated furnishing fee. We will announce the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculation based on that figure through the applicable program instructions and postings on the CMS Web site.

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

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) does not address the OPPS payment in CY 2005 and after for drugs, biologicals, and radiopharmaceuticals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals. Because there is no statutory provision that dictated payment for such drugs, biologicals, and radiopharmaceuticals in CY 2005, and because we had no hospital claims data to use in establishing a payment rate for them, we investigated several payment options for CY 2005 and discussed them in detail in the CY 2005 OPPS final rule with comment period (69 FR 65797 through 65799).

For CYs 2005 to 2007, we implemented a policy to provide separate payment for new drugs, biologicals, and radiopharmaceuticals with HCPCS codes (specifically those new drug, biological, and radiopharmaceutical HCPCS codes in each of those calendar years that did not crosswalk to predecessor HCPCS codes) but which did not have pass-through status, at a rate that was equivalent to the payment they received in the physician's office setting, established in accordance with the ASP methodology for drugs and biologicals, and based on charges adjusted to cost for radiopharmaceuticals. For CYs 2008 and 2009, we finalized a policy to provide payment for new drugs (excluding contrast agents and diagnostic radiopharmaceuticals) and biologicals (excluding implantable biologicals for CY 2009) with HCPCS codes, but which did not have pass-through status and were without OPPS hospital claims data, at ASP+5 percent and ASP+4 percent, respectively, consistent with the final OPPS payment methodology for other separately payable drugs and biologicals. New therapeutic radiopharmaceuticals were paid at charges adjusted to cost based on the statutory requirement for CY 2008 and CY 2009 and payment for new diagnostic radiopharmaceuticals was packaged in both years. For CY 2010, we continued to provide payment for new drugs (excluding contrast agents), and nonimplantable biologicals with HCPCS codes that do not have pass-through status and are without OPPS hospital claims data, at ASP+4 percent, consistent with the CY 2010 payment methodology for other separately payable nonpass-through drugs, and nonimplantable biologicals. We also finalized a policy to extend the CY 2009 payment methodology to new therapeutic radiopharmaceutical HCPCS codes, consistent with our final policy providing separate payment for therapeutic radiopharmaceuticals in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60581 through 60526), that do not crosswalk to CY 2009 HCPCS codes, do not have pass-through status, and are without OPPS hospital claims data, at ASP+4 percent.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46281), for CY 2011, we proposed to continue the CY 2010 payment methodology for new drugs (excluding contrast agents and

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

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

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

We did not receive any public comments specific to these proposals. While commenters generally supported our proposal to pay for separately payable drugs at ASP+6 percent and recommended that we pay no less than ASP+6 percent for separately payable drugs in CY 2011, these comments were not specific to new drugs and biologicals with HCPCS codes but without OPPS claims data. For more information regarding payment for separately payable drugs, including general public comments and our responses, we refer readers to section V.B.3.b of this final rule with comment period. In addition, commenters on the CY 2011 OPPS/ASC proposed rule objected to packaging payment for diagnostic radiopharmaceuticals and contrast agents in general, but these comments were not directed to new diagnostic radiopharmaceuticals or contrast agents with HCPCS codes but without OPPS claims data. We summarize these comments and provide our response in section V.A.2.d. of this final rule with comment period.

We are finalizing our CY 2011 proposal, without modification, as follows: Payment for new drugs (excluding contrast agents and diagnostic radiopharmaceuticals), nonimplantable biologicals, and therapeutic radiopharmaceuticals with HCPCS codes that do not crosswalk to CY 2010 HCPCS codes, but which do not have pass-through status and for which we do not have OPPS hospital claims data, will be made at ASP+5 percent for CY 2011, consistent with the proposed CY 2011 payment methodology for other new separately payable nonpass-through drugs, nonimplantable biologicals and therapeutic radiopharmaceuticals, for this final rule with comment period. In cases where ASP information is not available, payment will be made using WAC, and, if WAC is also unavailable, payment will be made at 95 percent of the product's most recent AWP. Further, payment for all new nonpass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals with HCPCS codes but for which we do not have OPPS claims data will be packaged for CY 2011. Finally, we are assigning status indicator "K" to HCPCS codes for new drugs and nonimplantable biologicals for which we do not have OPPS claims data and for which we have not granted pass-through status for CY 2011. With respect to new items for which we do not have ASP data, once their ASP data becomes available in later quarterly submissions, their payments will be adjusted so that the rates will be based on the ASP methodology and set to the finalized ASP amount of ASP+5 percent. This policy will ensure that they are paid for actual acquisition cost and pharmacy overhead for these new products.

For CY 2011, we also proposed to continue our CY 2010 policy to base payment for new therapeutic radiopharmaceuticals with HCPCS codes, but which do not have pass-through status and for which we do not have claims data, on the WACs for these products if ASP data for these therapeutic radiopharmaceuticals are not available. If the WACs are also unavailable, we proposed to make payment for a new therapeutic radiopharmaceutical at 95 percent of the product's most recent AWP because we would not have mean costs from hospital claims data upon which to base payment. Analogous to new drugs and biologicals, we proposed to continue our policy of assigning status indicator "K" to HCPCS codes for new therapeutic radiopharmaceuticals without OPPS claims data for which we have not granted pass-through status.

We did not receive any public comments specific to our proposal for new therapeutic radiopharmaceuticals with HCPCS codes but without pass-through status. However, commenters on the CY 2011 OPPS/ASC proposed

rule were generally supportive of the ASP methodology for payment for therapeutic radiopharmaceuticals in the HOPD, and we are finalizing an ASP payment methodology for separately payable therapeutic radiopharmaceuticals for CY 2011, as discussed in section V.B.3.c. of this final rule with comment period.

We are finalizing our CY 2011 proposals, without modification, to provide payment for new therapeutic radiopharmaceuticals with HCPCS codes but without pass-through status, if ASP information is not available, based on WAC. If WAC information is also unavailable, we will make payment for new therapeutic radiopharmaceuticals at 95 percent of the product's most recent AWP. In addition, we are assigning status indicator "K" to HCPCS codes for new therapeutic radiopharmaceuticals in CY 2010 that do not have pass-through status.

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

We did not receive any public comments on our proposal to announce, via the CMS Web site, any changes to the OPPS payment amounts for new drugs and biologicals on a quarterly basis. Therefore, we are finalizing our proposal and will update payment rates for new drugs, biologicals, and therapeutic radiopharmaceuticals, as necessary, in association with our quarterly update process and provide this information on the CMS Web site.

There are several nonpass-through drugs and biologicals that were payable in CY 2009 and/or CY 2010, for which we did not have CY 2009 hospital claims data available for the proposed rule and for which there are no other HCPCS codes that describe different doses of the same drug. These drugs and biologicals do have pricing information available for the ASP methodology. In the CY 2011 OPPS/ASC proposed rule (75 FR46281), we noted that there are currently no therapeutic radiopharmaceuticals in this category. In order to determine the packaging status of these products for CY 2011, we calculated an estimate of the per day cost of each of these items by multiplying the payment rate for each product based on ASP+6 percent, similar to other nonpass-through drugs and biologicals paid separately under the OPPS, by an estimated average number of units of each product that would typically be furnished to a patient during one administration in the hospital outpatient setting. We proposed to package items for which we estimated the per administration cost to be less than or equal to $70, which was the general packaging threshold that we proposed for drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals in CY 2011. We proposed to pay separately for items with an estimated per day cost greater than $70 (with the exception of diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals, which we proposed to continue to package regardless of cost (as discussed in more detail in section V.B.2.d. of this final rule with comment period)) in CY 2011. We proposed that the CY 2011 payment for separately payable items without CY 2009 claims data would be ASP+6 percent, similar to payment for other separately payable nonpass-through drugs and biologicals under the OPPS. In accordance with the ASP methodology used in the physician's office setting, in the absence of ASP data, we proposed to use the WAC for the product to establish the initial payment rate. However, we noted that if the WAC is also unavailable, we would make payment at 95 percent of the most recent AWP available.

We did not receive any public comments on our proposal to use estimated per day costs for these drugs and biologicals or on the resulting packaging status of these drugs and biologicals. However, upon receiving updated CY 2009 claims data for HCPCS codes J1835 (Injection, itraconazole, 50 mg), J2724 (Injection, protein c concentrate, intravenous, human 10 iu) and CPT code 90725 (Cholera vaccine for injectable use), for this final rule with comment period, we determined that we no longer needed to calculate an estimated average number of units for these two items. Therefore, for CY 2011, we calculated the packaging status for HCPCS codes J1835 and J2724 using our standard methodology as described above. These codes and their packaging status are discussed further in section V.B.2.b. of this final rule with comment period. We discuss the CY 2011 final status indicator for 90725 below. Therefore, we are finalizing our CY 2011 proposal, with modification, to use the estimated number of units per day included in Table 35 below, excluding the estimated number of units for HCPCS codes J1835, J2724 and CPT code 90725, to determine estimated per day costs for the corresponding drugs and biologicals for CY 2011. Further, we are finalizing our proposal to package those drugs with an estimated per day cost less than or equal to $70 and to provide separate payment for those drugs and biologicals (other than diagnostic radiopharmaceuticals, contrast agents and implantable biologicals) with estimated per day costs over $70 for CY 2011. For those drugs and biologicals that we determined to be separately payable in CY 2011, payment will be made at ASP+5 percent. If ASP information is not available, payment will be based on WAC or 95 percent of the most recently published AWP if WAC is not available. The final estimated units per day and status indicators for these items are displayed in Table 35 below.

TABLE 35—DRUGS AND BIOLOGICALS WITHOUT CY 2009 CLAIMS DATA

CY 2011 HCPCS code	CY 2011 long descriptor	Estimated average number of units per administration	CY 2011 SI	CY 2011 APC
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	1	K	1239
J0205	injection, alglucerase, per 10 units	420	K	0900

TABLE 35—DRUGS AND BIOLOGICALS WITHOUT CY 2009 CLAIMS DATA—Continued

CY 2011 HCPCS code	CY 2011 long descriptor	Estimated average number of units per administration	CY 2011 SI	CY 2011 APC
J0364	Injection, apomorphine hydrochloride, 1 mg	12	N	
J3355	Injection, urofollitropin, 75 IU	2	K	1741
J3485	Injection, zidovudine, 10 mg	42	N	
J7185	Injection, factor viii (antihemophilic factor, recombinant) (xyntha), per i.u	1750	K	1268
J9215	Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 iu	5	K	0865
J9226	Histrelin implant (supprelin la), 50 mg	1	K	1142
J9357	Injection, valrubicin, intravesical, 200 mg	4	K	1235
Q0515	Injection, sermorelin acetate, 1 microgram	70	K	3050
Q2017	Injection, teniposide, 50 mg	9.35	K	7035

Finally, there were five drugs and biologicals, shown in Table 36 below, that were payable in CY 2009, but for which we lacked CY 2009 claims data and any other pricing information for the ASP methodology for the CY 2011 OPPS/ASC proposed rule. In CY 2009, for similar items without CY 2007 claims data and without pricing information for the ASP methodology, we previously stated that we were unable to determine their per day cost and we packaged these items for the year, assigning these items status indicator "N."

For CY 2010, we finalized a policy to change the status indicator for nine drugs and biologicals to status indicator "E" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) that we understood were not currently sold or had been identified as obsolete. In addition, we noted that we would provide separate payment for these drugs and biologicals if pricing information reflecting recent sales becomes available mid-year in CY 2010 for the ASP methodology. If pricing information became available, we would assign the products status indicator "K" and pay for them separately for the remainder of CY 2010. In the CY 2011 OPPS/ASC proposed rule (75 FR 46282), for CY 2011, we proposed to continue our CY 2010 policy to assign status indicator "E" to drugs and biologicals that lack CY 2009 claims data and pricing information for the ASP methodology. We also proposed that if pricing information were to become available, we would assign the products status indicator "K" and would pay for them separately for the remainder of CY 2011.

We did not receive any public comments on our proposal to change the status indicators for drugs and biologicals without CY 2009 claims data or pricing information for the ASP methodology. We are finalizing our CY 2011 proposal, without modification, to assign status indicator "E" to these drugs and biologicals. As we have used updated claims data and ASP pricing information for this final rule with comment period, we have newly identified, for this final rule with comment period, HCPCS codes Q4117 (Hyalomatrix, per square centimeter), Q4119 (Matristem wound matrix, per square centimeter), Q4120 (Matristem burn matrix, per square centimeter), and CPT code 90725 (Cholera vaccine for injectable use) as lacking CY 2009 claims data and any other pricing information for the ASP methodology. Therefore, in addition to the HCPCS codes we proposed to assign status indicator "E" for CY 2011 on this basis in the proposed rule, we are assigning status indicator "E" to HCPCS codes Q4117, Q4119, and Q4120 and CPT code 90725 for CY 2011. All drugs and biologicals without CY 2009 hospital claims data and data based on the ASP methodology that are assigned status indicator "E" on this basis at the time of this final rule with comment period for CY 2011 are displayed in Table 36 below.

TABLE 36—DRUGS AND BIOLOGICALS WITHOUT CY 2009 CLAIMS DATA AND WITHOUT PRICING INFORMATION FOR THE ASP METHODOLOGY

CY 2011 HCPCS code	CY 2011 long descriptor	Final CY 2011 SI
90725	Cholera vaccine for injectable use	E
J0190	Injection, biperiden lactate, per 5 mg	E
J1435	Injection, estrone, per 1 mg	E
J3320	Injection, spectinomycin dihydrochloride, up to 2 gm	E
J3400	Injection, trifluprom azine hcl, up to 20 mg	E
Q0174	Thiethylperazine maleate, 10 mg, oral, FDA approved prescription anti-emetic, for use as a compl	E
Q4117	Hyalomatrix, per square centimeter	E
Q4119	Matristem wound matrix, per square centimeter	E
Q4120	Matristem burn matrix, per square centimeter	E

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

A. Background

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments (defined in sections IV.A.1. and V.A.1. of this final rule with comment period) for drugs, biologicals, radiopharmaceuticals, and categories of devices for a given year to an "applicable percentage" (defined below) of total program payments estimated to be made for all covered services under the hospital OPPS furnished for that year. For a year (or portion of a year) before CY 2004, the applicable percentage is 2.5 percent; for CY 2004 and subsequent years, the applicable percentage is a percentage specified by the Secretary up to (but not to exceed) 2.0 percent.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a uniform prospective reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We make an estimate of pass-through spending to determine not only whether payments exceed the applicable percentage, but also to determine the appropriate prorata reduction to the conversion factor for the projected level of pass-through spending in the following year in order to ensure that total estimated pass-through spending for the prospective payment year is budget neutral as required by section 1883(t)(6)(E) of the Act.

For devices, developing an estimate of pass-through spending in CY 2011 entails estimating spending for two groups of items. The first group of items consists of device categories that were recently made eligible for pass-through payment and that will continue to be eligible for pass-through payment in CY 2011. The CY 2008 OPPS/ASC final rule with comment period (72 FR 66778) describes the methodology we have used in previous years to develop the pass-through spending estimate for known device categories continuing into the applicable update year. The second group contains items that we know are newly eligible, or project would be newly eligible, for device pass-through payment in the remaining quarters of CY 2010 or beginning in CY 2011. As discussed in section V.A.4. of the CY 2010 OPPS/ASC final rule with comment period (74 FR 60476), beginning in CY 2010, the pass-through evaluation process and pass-through payment for implantable biologicals newly approved for pass-through payment beginning on or after January 1, 2010, that are surgically inserted or implanted (through a surgical incision or a natural orifice) is the device pass-through process and payment methodology only. As we proposed in the CY 2010 OPPS/ASC proposed rule (75 FR 46283), for this final rule with comment period, the estimate of pass-through spending for implantable biologicals newly eligible for pass-through payment beginning in CY 2011 is included in the pass-through spending estimate for this second group of device categories. The sum of the CY 2011 pass-through estimates for these two groups of device categories equals the total CY 2011 pass-through spending estimate for device categories with pass-through status.

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

For drugs and biologicals eligible for pass-through payment, section 1833(t)(6)(D)(i) of the Act establishes the pass-through payment amount as the amount by which the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary) exceeds the portion of the otherwise applicable fee schedule amount that the Secretary determines is associated with the drug or biological. Because we are paying for most nonpass-through separately payable drugs and nonimplantable biologicals under the CY 2011 OPPS at ASP+5 percent, which represents the otherwise applicable fee schedule amount associated with most pass-through drugs and biologicals, and because we are paying for CY 2011 pass-through drugs and nonimplantable biologicals at ASP+6 percent or the Part B drug CAP rate, if applicable, our estimate of drug and nonimplantable biological pass-through payment for CY 2011 is not zero, as discussed below. Furthermore, payment for certain drugs, specifically diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals without pass-through status, will always be packaged into payment for the associated procedures because these products will never be separately paid. However, all pass-through diagnostic radiopharmaceuticals, contrast agents, and those implantable biologicals with pass-through status approved prior to CY 2010 will be paid at ASP+6 percent or the Part B drug CAP rate, if applicable, like other pass-through drugs and biologicals. Therefore, our estimate of pass-through payment for all diagnostic radiopharmaceuticals and contrast agents and those implantable biologicals with pass-through status approved prior to CY 2010 is not zero.

In section V.A.4. of this final rule with comment period, we discuss our policy to determine if the cost of certain "policy-packaged" drugs, including diagnostic radiopharmaceuticals and contrast agents, are already packaged into the existing APC structure. If we determine that a "policy-packaged" drug approved for pass-through payment resembles predecessor diagnostic radiopharmaceuticals or contrast agents already included in the costs of the APCs that would be associated with the drug receiving pass-through payment, we offset the amount of pass-through payment for diagnostic radiopharmaceuticals and contrast agents. For these drugs, the APC offset amount is the portion of the APC payment for the specific procedure

performed with the pass-through diagnostic radiopharmaceutical or contrast agent that is attributable to diagnostic radiopharmaceuticals or contrast agents, which we refer to as the "policy-packaged" drug APC offset amount. If we determine that an offset is appropriate for a specific diagnostic radiopharmaceutical or contrast agent receiving pass-through payment, we reduce our estimate of pass-through payment for these drugs by this amount. We have not established a policy to offset pass-through payment for implantable biologicals when approved for pass-through payment as a drug or biological, that is, for CY 2009 and earlier, so we consider full payment at ASP+6 percent for these implantable biologicals receiving biological pass-through payment as of CY 2011 in our estimate of CY 2011 pass-through spending for drugs and biologicals.

We note that the Part B drug CAP program has been postponed beginning January 1, 2009. We refer readers to the Medicare Learning Network (MLN) Matters Special Edition article SE0833 for more information. As of the publication of this final rule with comment period, the postponement of the Part B drug CAP program is still in effect. As in past years, consistent with our proposal, for this final rule with comment period, we do not have an effective Part B drug CAP rate for pass-through drugs and biologicals.

Similar to pass-through estimates for devices, the first group of drugs and biologicals requiring a pass-through payment estimate consists of those products that were recently made eligible for pass-through payment and that will continue to be eligible for pass-through payment in CY 2011. The second group contains drugs and nonimplantable biologicals that we know are newly eligible, or project will be newly eligible, in the remaining quarters of CY 2010 or beginning in CY 2011. The sum of the CY 2011 pass-through estimates for these two groups of drugs and biologicals equals the total CY 2011 pass-through spending estimate for drugs and biologicals with pass-through status.

B. Estimate of Pass-Through Spending

As we proposed in the CY 2011 OPPS/ASC proposed rule (75 FR 46284), we are finalizing a policy of setting the applicable pass-through payment percentage limit at 2.0 percent of the total projected OPPS payments for CY 2011, consistent with our OPPS policy from CY 2004 through CY 2010 (74 FR 60530).

For the first group of devices for pass-through payment estimate purposes, there currently are no device categories receiving pass-through payment in CY 2010 that will continue for payment during CY 2011. Therefore, there is no device pass-through payment estimate for the first group of pass-through device categories.

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

In estimating our proposed CY 2011 pass-through spending for device categories in the second group, that is, device categories that we knew at the time of the development of the CY 2011 OPPS/ASC proposed rule would be newly eligible for pass-through payment in CY 2011 (of which there were none), additional device categories (including categories that describe implantable biologicals) that we estimated could be approved for pass-through status subsequent to the development of the proposed rule and before January 1, 2011, and contingent projections for new categories (including categories that describe implantable biologicals in the second through fourth quarters of CY 2011), we proposed to use the general methodology described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66778), while also taking into account recent OPPS experience in approving new pass-through device categories.

For this CY 2011 OPPS/ASC final rule with comment period, one new device category, C1749 (Endoscope, retrograde imaging/illumination colonoscope device (implantable)) became effective October 1, 2010, and will continue for CY 2011. There also are possible new device categories for pass-through payment based on current applications. Therefore, the estimate of CY 2011 pass-through spending for this second group of device categories is $42.3 million.

For this CY 2011 final rule with comment period, we are finalizing our proposal to continue our established methodology. Employing our established methodology that the estimate of pass-through device spending in CY 2011 incorporates CY 2011 estimates of pass-through spending for known device categories continuing in CY 2011, those known or projected to be first effective January 1, 2011, and those device categories projected to be approved during subsequent quarters of CY 2010 or CY 2011, we estimate for this CY 2011 OPPS/ASC final rule with comment period the total pass-through spending for device categories for CY 2011 to be $42.3 million.

We did not receive any public comments regarding our proposed methodology for estimating transitional pass-through spending for devices for CY 2011. Therefore we are adopting our final estimate of $42.3 million for total pass-through spending for device categories for CY 2011.

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

In the CY 2011 OPPS/ASC proposed rule, for the known drugs and biologicals (excluding diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals) that would be continuing on pass-through status in CY 2011, we estimated the proposed pass-through payment amount as the difference between ASP+6 percent or the Part B drug CAP rate, as applicable, and the proposed payment rate for non-pass through drugs and nonimplantable

biologicals that are separately paid at ASP+6 percent, aggregated across the projected CY 2011 OPPS utilization of these products, which was zero for this group of drugs and biologicals for the proposed rule. However, as discussed in V.B.3. of this final rule with comment period, the final payment rate for nonpass-through drugs and nonimplantable biologicals that receive separate payment will be ASP+5 percent for CY 2011. Therefore, for this final rule with comment period, we estimate the pass-through payment amount for this group of drugs and biologicals as the difference between ASP+6 percent or the Part B drug CAP rate, as applicable, and the final CY 2011 payment rate for nonpass-through drugs and nonimplantable biologicals of ASP+5 percent, which is not zero. Because payment for a diagnostic radiopharmaceutical or contrast agent would be packaged if the product were not paid separately due to its pass-through status, as we proposed and are finalizing in the final rule with comment period, we include in the final CY 2011 pass-through estimate the difference between payment for the drug or biological at ASP+6 percent (or WAC+6 percent, or 95 percent of AWP, if ASP information is not available) and the "policy-packaged" drug APC offset amount, if we determined that the diagnostic radiopharmaceutical or contrast agent approved for pass-through payment resembles predecessor diagnostic radiopharmaceuticals or contrast agents already included in the costs of the APCs that would be associated with the drug receiving pass-through payment. Because payment for an implantable biological eligible for pass-through payment in CY 2009 and continuing on pass-through status in CY 2011 would be packaged if the product were not paid separately due to its pass-through status and because we had not established a pass-through payment offset policy for implantable biologicals when approved for pass-through payment as biologicals, that is, for CY 2009 and earlier, as we proposed, we include in the final CY 2011 pass-through spending estimate the full payment for these implantable biologicals at ASP+6 percent (or WAC+6 percent or 95 percent of AWP, if ASP information is not available). For this final rule with comment period, we are finalizing our proposed methodology and, using that methodology, we calculated a final spending estimate for this first group of drugs and biologicals to be $8.9 million and we are finalizing our established methodology.

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

We are finalizing our proposed methodology for estimating CY 2011 pass-through payments for this second group of drugs, and for this final rule with comment period, we calculated a final spending estimate for this second group of drugs and biologicals to be $6.6 million.

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

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

The final CY 2011 pass-through spending estimate for the first group of pass-through device categories is $0. The final estimate for this final rule with comment period for the second group of pass-through device categories is $42.3 million. Therefore, our estimate for total pass-through spending for device categories for this final rule with comment period is $42.3 million.

The final estimate for pass-through spending for the first group of drugs and biologicals is $8.9 million for CY 2011. The final estimate for pass-through spending for the second group of drugs and biologicals is $6.6 million for CY 2011. As discussed in section V.A. of this final rule with comment period, radiopharmaceuticals are considered drugs for pass-through purposes. Therefore, we included radiopharmaceuticals in our final CY 2011 pass-through spending estimate for drugs and biologicals. Our CY 2011 allocation in this final rule with comment period for total pass-through spending for drugs and biologicals is $15.5 million.

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

nonimplantable biologicals that first become eligible for pass-through payment during CY 2011 will be approximately $57.7 million (approximately $42.3 million for device categories and approximately $15.5 million for drugs and biologicals), which represents 0.15 percent of total OPPS projected total payments for CY 2011. We estimate that pass-through spending in CY 2011 would not amount to 2.0 percent of total projected OPPS CY 2011 program spending.

We did not receive any public comments on our proposed methodology or estimates. Accordingly, we are finalizing our proposed methodology for estimating CY 2011 OPPS pass-through spending for drugs, biologicals, radiopharmaceuticals, and device categories without modification. Our final pass-through estimate for CY 2011 is $57.7 million.

VII. OPPS Payment for Brachytherapy Sources

A. Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. OPPS Payment Policy

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46287), we proposed to use the median costs from CY 2009 claims data for setting the proposed CY 2011 payment rates for brachytherapy sources, as we proposed for most other items and services that will be paid under the CY 2011 OPPS. We proposed to continue the other payment policies for brachytherapy sources we finalized in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60537). We proposed to pay for the stranded and non-stranded NOS codes, HCPCS codes C2698 and C2699, at a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively, on a per source basis (as opposed, for example, to a per mCi), which is based on the policy we established in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66785). The proposed payment methodology for NOS sources would provide payment to a hospital for new sources, and at the same time encourage interested parties to quickly bring new sources to our attention so that specific coding and payment could be established.

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

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

payments in CY 2011 under certain circumstances through the 7.1 percent rural adjustment, as described in section II.E. of this final rule with comment period.

Comment: Several commenters recommended that brachytherapy sources be paid at charges adjusted to cost for CY 2011. A few commenters stated that some providers have decided to discontinue offering brachytherapy services because the OPPS payment rates for sources were too low. Several commenters noted several reasons why they recommend that CMS revert to the charges-adjusted-to-cost methodology for determining payment rates for brachytherapy sources. These commenters contended that there are ongoing concerns regarding the claims data used to establish the prospective payment. The commenters asserted that CY 2009 brachytherapy source claims data show significant variations in unit median cost, that there is continuation in the CY 2009 data of longstanding instability and fluctuation of costs, and that one-half of the sources have proposed payment rates based on 50 or fewer hospitals (and a decline from CY 2010 to CY 2011). One commenter asserted that some brachytherapy sources showed decreased frequencies for CY 2009, and that decreased claims result in decreased payment.

One commenter gave an example of a rank order anomaly in median cost of HCPCS code C2635, high activity palladium (proposed rule median of $30.19 per unit), versus low activity palladium, HCPCS codes C2641 and C2640, non-stranded and stranded palladium sources, with proposed rule medians of $63.59 and $64.98, respectively. This commenter also opined that the number of Medicare beneficiaries treated with brachytherapy may have declined from CY 2008 to CY 2009, claiming its data analysis generated 17,681 brachytherapy source claims using 2008 data, and 16,456 claims using CY 2009 data. One commenter claimed that Medicare program payment would be $9.5 million less using the charges-adjusted-to-cost payment methodology than Medicare payment for brachytherapy sources when made under the prospective payment system based on median costs in CY 2011, as it claimed was the case for CY 2010.

One commenter noted its support for our proposed continuance of the policy of assigning new brachytherapy sources for which we have no claims data to their own APCs, and to consider external data for establishing rates, and recommended that we finalize this proposal.

Response: As we stated previously (72 FR 66782 and 74 FR 60534), we believe that median costs based on hospital claims data for brachytherapy sources have produced reasonably consistent per-source cost estimates over the past several years, comparable to the patterns we have observed for many other OPPS services whose payments are set based upon relative payment weights from claims data. We believe that our per-source payment methodology specific to each source's radioisotope, radioactive intensity, and stranded or non-stranded configuration, supplemented by payment based on the number of sources used in a specific clinical case, adequately accounts for the major expected sources of variability across treatments. As we also explained previously (72 FR 66782 and 74 FR 60535), a prospective payment system such as the OPPS relies on the concept of averaging, where the payment may be more or less than the estimated cost of providing a service for a particular patient, but with the exception of outlier cases, it is adequate to ensure access to appropriate care. In the case of brachytherapy sources for which the law requires separate payment groups, without packaging, the costs of these individual items could be expected to show greater variation than some other APCs under the OPPS because higher variability in costs for some component items and services is not balanced with lower variability for others and because relative weights are typically estimated using a smaller set of claims. Nevertheless, we believe that prospective payment for brachytherapy sources based on median costs from claims calculated according to the standard OPPS methodology is appropriate and provides hospitals with the greatest incentives for efficiency in furnishing brachytherapy treatment.

Under the budget neutral provision for the OPPS, it is the relativity of costs of services, not their absolute costs, that is important, and we believe that brachytherapy sources are appropriately paid according to the standard OPPS payment approach. Furthermore, we are not concerned that some sources may have median costs and payment rates based on 50 or fewer providers, because it is not uncommon for OPPS prospective payment rates to be based on claims from a relatively small number of hospitals that furnished the service in the year of claims data available for the OPPS update year. Fifty hospitals may report hundreds of brachytherapy source claims for many cases and comprise the universe of providers using particular low volume sources, for which we are required to pay separately by statute. Further, our methodology for estimating median costs for brachytherapy sources utilizes all line-item charges for those sources, which allows us to use all hospital reported charge and estimated cost information to set payment rates for these items. Therefore, no brachytherapy source claims are lost. We have no reason to believe that prospective payment rates based on claims from those providers furnishing a particular source do not appropriately reflect the cost of that source to hospitals. As for most other OPPS services, we note that the median costs for brachytherapy sources are based upon the costs of those providers that furnished the sources in CY 2009. Hospitals individually determine their charge for an item or service, and one of Medicare's primary requirements for setting a charge is that it be reasonably and consistently related to the cost of the item or service for that facility (Medicare Provider Reimbursement Manual, Part I, Section 2203). We then estimate a cost from that charge using the hospital's most recent Medicare hospital cost report data in our standard OPPS ratesetting process. In as much as we paid hospitals at charges adjusted to cost for brachytherapy sources in CY 2009 based on these exact charges, we believe a hospital's individual charges are accurate for its institution.

In the case of high and low activity iodine-125 sources, our claims data showed that the cost of the high activity source is greater than the low activity sources. However, this relationship is reversed for palladium-103 sources, as one commenter pointed out. We have no information about the expected cost differential between high and low activity sources of various isotopes other than what is available in our claims and hospital cost report data. For high activity palladium-103, only 11 hospitals reported this service in CY 2009, compared to 158 and 256 providers for low activity palladium sources described by HCPCS codes C2640 and C2641, respectively. As we stated regarding this issue in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60535), it is clear that fewer providers furnished high activity palladium-103 sources than low activity palladium sources, and we expect that the hospital cost distribution for those hospitals could be different than the cost distribution of the large number of providers reporting the low activity sources. These varied cost distributions clearly contribute to the observed relationship in median

costs between the different types of sources. However, we see no reason why our standard ratesetting methodology for brachytherapy sources that relies on all claims from all hospitals furnishing brachytherapy sources would not yield valid median costs for those hospitals furnishing the different brachytherapy sources upon which CY 2011 prospective payments rates are based.

Prospective payment for brachytherapy sources based on their median costs makes the source payment an integral part of the OPPS, rather than a separate cost-based payment methodology within the OPPS. We believe that consistent and predictable prospectively established payment rates under the OPPS for brachytherapy sources are appropriate because we do not believe that the hospital resource costs associated with specific brachytherapy sources would vary greatly across hospitals or clinical conditions under treatment, other than through differences in the numbers of sources utilized that would be accounted for in the standard OPPS payment methodology we are finalizing for CY 2011.

We agree that high dose rate (HDR) brachytherapy sources such as HDR irirdium-192 have a fixed active life and must be replaced every 90 days; as a result, hospitals' per-treatment cost for the source would be dependent on the number of treatments furnished per source. The source cost must be amortized over the life of the source. Therefore, in establishing their charges for HDR iridium, we expect hospitals to project the number of treatments that would be provided over the life of the source and establish their charges for the source accordingly, as we have stated previously (72 FR 66783 and 74 FR 60535). For most such OPPS services, our practice is to establish prospective payment rates based on the median costs from hospitals' claims data, to provide incentives for efficient and cost-effective delivery of these services.

We do not agree with the commenters that prospective brachytherapy source payment based on median costs would increase aggregate Medicare expenditures using the charges-adjusted-to-cost methodology compared to the proposed prospective payment methodology. Our past studies, such as that discussed in the CY 2010 final rule with comment period (74 FR 60535), have shown that payment at charges adjusted to cost results in higher aggregate payment for brachytherapy sources than does prospective payment. As we indicated in last year's final rule with comment period (74 FR 60535), we have traditionally found that charge inflation for brachytherapy sources appears to be higher than the market basket inflation update applicable to prospective payments under the OPPS. Therefore, we found that the estimated payments we calculated for brachytherapy charges adjusted to cost were greater than the estimated prospective payment rates because the hospital market basket grows more slowly than the charges for brachytherapy sources. The commenter did not provide its aggregate payments study, and we do not know whether the commenter's study took into account factors such as charge inflation. Moreover, the OPPS is a prospective payment system that ensures equitable prospective payment of services across providers, and efficient use of resources, including brachytherapy sources, which since CY 2010 are part of OPPS prospective payment.

Concerning the comment that some providers have decided to discontinue offering brachytherapy services because the OPPS payment rates for sources were too low, there are many reasons why some providers may discontinue services, such as brachytherapy. For example, changes in medical technology or emphasis on different treatment forms for a medical condition can influence whether a set of services are continued. In addition, providers accept payment from a number of payers in addition to Medicare, and we believe a global shift by a provider to discontinue any services would be influenced by factors other than our payment rates alone.

We believe that the comment that compared the frequency of brachytherapy sources in the CY 2010 final rule data to the frequency of brachytherapy sources in the CY 2011 proposed rule data and concluded that there is a significant decrease between the frequency of services is flawed because the volume of claims in a proposed rule data set and the final rule data set will never be comparable for any given year. Typically, the volume of claims in final rule data generally increases in frequency between 10 and 15 percent above the volume in the proposed rule data due to addition of claims processed between January 1 and July 1 of the current year between the proposed and final OPPS rules. For the CY 2011 proposed rule, we used CY 2009 claims processed before January 1, 2010, but for this final rule, we used CY 2009 claims processed before July 1, 2010. Comparing the frequency of brachytherapy sources in the CY 2010 final rule data (CY 2008 claims processed before July 1, 2009) to the frequency of brachytherapy sources in the CY 2011 final rule data (CY 2009 claims processed before July 1, 2010), we do observe that the aggregate frequency of brachytherapy sources used for setting the medians in this CY 2011 OPPS/ASC final rule with comment period (approximately 34,000 in the CY 2009 claims) is less than the frequency of brachytherapy sources in the CY 2010 OPPS (slightly less than 36,000 in the CY 2008 claims). However, we note that this reduction between CY 2008 and CY 2009 cannot be attributed to the effects of prospective payment under the OPPS because payment for brachytherapy sources in both CY 2008 and CY 2009 was made at charges adjusted to cost.

We appreciate the support for our proposed continuance of the policy of assigning new brachytherapy sources for which we have no claims data to their own APCs, with prospective payment rates set based on our consideration of external data and other relevant information regarding the expected costs of the sources to hospitals. We will continue that policy.

After consideration of the public comments we received, we are finalizing our proposal to pay for brachytherapy sources at prospective payment rates based on their source-specific median costs for CY 2011. The separately payable brachytherapy source HCPCS codes, long descriptors, APCs, status indicators, and approximate APC median costs for CY 2011 are presented in Table 37 below. We also are finalizing our proposals to continue our policies regarding payment for NOS codes for stranded and non-stranded sources and new brachytherapy sources for which we have no claims data. Specifically, we are finalizing our proposals to continue payment for stranded and non-stranded NOS codes, HCPCS codes C2698 and C2699, at a rate equal to the lowest stranded or non-stranded prospective payment for such sources, respectively, as discussed in the CY 2008 OPPS/ASC final rule with commenter period (72 FR 66786); and our proposal to assign HCPCS codes for new brachytherapy sources to their own APCs, with payment rates based on consideration of external data and other relevant information, in the absence of claims data. Once claims data are available, our standard ratesetting process will be applied to the calculation of the median cost for the new brachyhterapy source.

Consistent with our policy regarding APC payments made on a prospective basis, we are finalizing our proposal to subject the cost of brachytherapy

sources to the outlier provision of section 1833(t)(5) of the Act, and also to subject brachytherapy source payment weights to scaling for purposes of budget neutrality.

TABLE 37—SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2011

CY 2010 HCPCS code	CY 2010 long descriptor	CY 2011 APC	CY 2011 SI	CY 2011 approximate APC median cost
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	2632	U	$21
C1716	Brachytherapy source, non-stranded, Gold-198, per source	1716	U	188
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source.	1717	U	217
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source.	1719	U	28
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	2616	U	16,392
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	U	56
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	U	28
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	2636	U	37
C2638	Brachytherapy source, stranded, Iodine-125, per source	2638	U	41
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	2639	U	36
C2640	Brachytherapy source, stranded, Palladium-103, per source	2640	U	72
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	2641	U	65
C2642	Brachytherapy source, stranded, Cesium-131, per source	2642	U	123
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	2643	U	66
C2698	Brachytherapy source, stranded, not otherwise specified, per source	2698	U	*41
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	2699	U	*28

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

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

VIII. OPPS Payment for Drug Administration Services

A. Background

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

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

In CY 2006, as anticipated, the CPT Editorial Panel revised its coding structure for drug administration services and incorporated new concepts, such as initial, sequential, and concurrent services, into a structure that previously distinguished services based on type of administration (chemotherapy/nonchemotherapy), method of administration (injection/infusion/push), and for infusion services, first hour and additional hours. For CY 2006, we implemented the CY 2006 drug administration CPT codes that did not reflect the concepts of initial, sequential, and concurrent services under the OPPS, and we created HCPCS C-codes that generally paralleled the CY 2005 CPT codes for reporting these other services.

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

For CY 2009, we continued to allow hospitals to use the full set of CPT codes for drug administration services but moved from a six-level APC structure to a five-level APC structure, as a result of a hospital cost analysis and detailed clinical review. We note that, while there were changes in the CPT numerical coding for nonchemotherapy drug administration services in CY 2009, the existing CPT codes were only renumbered, and there were no significant changes to the code descriptors themselves. As we discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68672), the CY 2009 ratesetting process afforded us the first opportunity to examine hospital claims data for the full set of CPT codes that reflected the concepts of initial,

sequential, and concurrent services. For CY 2009, we performed our standard annual OPPS review of the clinical and resource characteristics of the drug administration CPT codes assigned to the six-level CY 2008 APC structure based on the CY 2007 claims data available for the CY 2009 OPPS/ASC proposed rule. As a result of our hospital cost analysis and detailed clinical review, we adopted a five-level APC structure for CY 2009 drug administration services to more appropriately reflect their resource utilization in APCs that also group clinically similar services. As we noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68671), these APCs generally demonstrated the clinically expected and actually observed comparative relationships between the median costs of different types of drug administration services, including initial and additional services; chemotherapy and other diagnostic, prophylactic, or therapeutic services; injections and infusions; and simple and complex methods of drug administration.

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

B. Coding and Payment for Drug Administration Services

In the CY 2011 OPPS/ASC proposed rule (75 FR 46290), for CY 2011, we proposed to continue to use the full set of CPT codes for reporting drug administration services and to continue to pay separately for the same set of drug administration codes under the CY 2011 OPPS as were paid separately in the CY 2010 OPPS. In addition, as a part of our standard annual review, we analyzed the CY 2009 claims data that reflect assignments of CPT codes for drug administration into the five-level APC structure and found that the assignment of separately paid drug administration codes to five APCs continued to appropriately reflect the relative resources required to furnish these services. In addition, as has been our standard policy since the CY 2007 OPPS (71 FR 68117), we proposed to continue to include all separately payable drug administration add-on codes on the bypass list so that we can use the cost data we derive from claims for these codes to establish payment rates for them.

Since this approach was first adopted for CY 2007, we have updated and expanded the bypass methodology to reflect the changing drug administration HCPCS codes that are recognized under the OPPS. We placed all of the separately payable add-on CPT codes for drug administration services, including the sequential infusion and intravenous push codes, on the bypass list in CY 2009 (73 FR 68513) in order to continue this framework for transforming these otherwise unusable multiple bills into "pseudo" single claims that can be used for OPPS ratesetting purposes. We believe that this longstanding methodology results in the appropriate payment rates for the add-on CPT codes for drug administration. As such, in the CY 2011 OPPS/ASC proposed rule (75 FR 46290), we proposed to continue to use this methodology for the CY 2011 OPPS because we believe this takes into account all of the packaging on claims for drug administration services and, therefore, provides a reasonable framework for developing the median costs for drug administration services that are often provided in combination with one another (74 FR 60539).

At its February 2010 meeting, the APC Panel recommended that CMS make CPT code 96368 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)) and CPT code 93676 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary, separately payable procedure)) separately payable for the CY 2011 OPPS at an appropriate payment rate as determined by CMS. In the CY 2011 OPPS/ASC proposed rule (75 FR 46290), we proposed to not accept this APC Panel recommendation because each of these two codes describe services that, by definition, are always provided in conjunction with an initial drug administration code and therefore are appropriately packaged into the payment for the separately payable services that they usually accompany. We stated that these services have been packaged since the inception of the OPPS, and we continue to believe they are appropriately packaged into the payment for the separately payable services without which, under CPT guidelines and definitions, they cannot be appropriately reported. We refer readers to section II.A.3. of this final rule with comment period for a more detailed discussion of payment for packaged services, including our discussion of the comments we received and our responses to comments on our proposal to continue to package payment for CPT codes 96368 and 96376 into the payment for the separately paid procedures with which they are furnished.

Comment: Several commenters supported the proposed five-level APC structure for drug administration services. Some commenters requested that CMS continue to evaluate the five-level structure annually.

Response: We appreciate the commenters' support. As part of our standard methodology, we expect to continue to annually review the configuration of drug administration APCs in the future.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to continue to use the five-level APC structure for drug administration services CY 2011. Table 38 below displays the final configurations of the five drug administration APCs for CY 2011. We believe the updated CY 2009 claims data and the most recent cost report data for the drug administration CPT show that these codes share sufficiently similar clinical and resource characteristics to justify their continued placement in the five levels of drug administration APCs that were in effect in the CY 2010 OPPS. The median cost for each of the separately paid drug administration CPT codes is contained in the CPT median cost file that is provided as supporting documentation to this final rule with comment period at the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*. The CY 2011 payment rate for each of the drug administration APCs is contained in Addendum B of this final rule with comment period.

TABLE 38—CY 2011 DRUG ADMINISTRATION APCS

CY 2011 HCPCS Code	Final CY 2011 APC	Final CY 2011 approximate APC median cost	CY 2011 long descriptor
90471	0436	$26	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid).
90472			Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).
90473			Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).
90474			Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).
95115			Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection.
95117			Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections.
95165			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses).
96361			Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure).
96366			Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure).
96371			Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure).
96372			Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
96379			Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion.
96549			Unlisted chemotherapy procedure.
95144	0437	$36	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials).
95145			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom.
95148			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms.
95149			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms.
95170			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses).
96367			Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure).
96370			Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure).
96373			Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial.
96374			Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.
96375			Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in additional to code for primary procedure).
96401			Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic.
96402			Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic.
96405			Chemotherapy administration; intralesional, up to and including 7 lesions.
96415			Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure).
95146			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms.
95147			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms.
96360			Intravenous infusion, hydration; initial, 31 minutes to 1 hour.
96411			Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure).
96417	0438	$75	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure).
96420			Chemotherapy administration, intra-arterial; push technique.
96423			Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure).
96542			Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents.

TABLE 38—CY 2011 DRUG ADMINISTRATION APCS—Continued

CY 2011 HCPCS Code	Final CY 2011 APC	Final CY 2011 approximate APC median cost	CY 2011 long descriptor
95990	0439	$127	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular).
95991	.....	.....	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician.
96365	.....	.....	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour.
96369	.....	.....	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s).
96406	.....	.....	Chemotherapy administration; intralesional, more than 7 lesions.
96409	.....	.....	Chemotherapy administration; intravenous, push technique, single or initial substance/drug.
96440	.....	.....	Chemotherapy administration into pleural cavity, requiring and including thoracentesis.
96521	.....	.....	Refilling and maintenance of portable pump.
96522	.....	.....	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial).
96413	0440	$204	Chemotherapy administration; intravenous infusion technique; up to 1 hour, single or initial substance/drug.
96416	.....	.....	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump.
96422	.....	.....	Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour.
96425	.....	.....	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump.
96445	.....	.....	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis.
96450	.....	.....	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture.
C8957	.....	.....	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than eight hours), requiring use of portable or implantable pump.

IX. OPPS Payment for Hospital Outpatient Visits

A. Background

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

As we proposed in the CY 2011 OPPS/ASC proposed rule (75 FR 46294), we are continuing to recognize these CPT and HCPCS codes describing clinic visits, Type A and Type B emergency department visits, critical care services, and trauma team activation provided in association with critical care services for CY 2011. These codes are listed below in Table 39.

TABLE 39—HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES

CY 2011 HCPCS Code	CY 2011 descriptor
Clinic Visit HCPCS Codes	
99201	Office or other outpatient visit for the evaluation and management of a new patient (Level 1).
99202	Office or other outpatient visit for the evaluation and management of a new patient (Level 2).
99203	Office or other outpatient visit for the evaluation and management of a new patient (Level 3).
99204	Office or other outpatient visit for the evaluation and management of a new patient (Level 4).
99205	Office or other outpatient visit for the evaluation and management of a new patient (Level 5).
99211	Office or other outpatient visit for the evaluation and management of an established patient (Level 1).
99212	Office or other outpatient visit for the evaluation and management of an established patient (Level 2).
99213	Office or other outpatient visit for the evaluation and management of an established patient (Level 3).
99214	Office or other outpatient visit for the evaluation and management of an established patient (Level 4).

TABLE 39—HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES—Continued

CY 2011 HCPCS Code	CY 2011 descriptor
99215	Office or other outpatient visit for the evaluation and management of an established patient (Level 5).
Emergency Department Visit HCPCS Codes	
99281	Emergency department visit for the evaluation and management of a patient (Level 1).
99282	Emergency department visit for the evaluation and management of a patient (Level 2).
99283	Emergency department visit for the evaluation and management of a patient (Level 3).
99284	Emergency department visit for the evaluation and management of a patient (Level 4).
99285	Emergency department visit for the evaluation and management of a patient (Level 5).
G0380	Type B emergency department visit (Level 1).
G0381	Type B emergency department visit (Level 2).
G0382	Type B emergency department visit (Level 3).
G0383	Type B emergency department visit (Level 4).
G0384	Type B emergency department visit (Level 5).
Critical Care Services HCPCS Codes	
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes.
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes.
G0390	Trauma response associated with hospital critical care service

During the February 2010 APC Panel meeting, the APC Panel recommended that CMS continue to report on clinic and emergency department visits and observation services in the claims data, and that if CMS identifies changes in patterns of utilization or cost, it bring those issues before the Visits and Observation Subcommittee for future consideration. The APC Panel also recommended that the work of the Visits and Observation Subcommittee continue. In the CY 2011 OPPS/ASC proposed rule (75 FR 46296), we indicated that we are adopting these recommendations and plan to provide the requested data and analyses to the APC Panel at an upcoming meeting.

At its August 2010 meeting, the APC Panel recommended that CMS continue to report claims data for clinic and emergency department visits and observation services, critical care, and trauma activation services and, if CMS identifies changes in patterns of utilization or cost, that it bring those issues before the APC Panel for future consideration. The APC Panel also recommended that CMS provide additional information about critical care patients with a primary diagnosis of unspecified chest pain or other chest pain, such as the three most common secondary diagnoses and patient disposition. The APC Panel recommended that the work of the Visits and Observation Subcommittee continue and that Randall Oyer, M.D., be named chair of the Visits and Observation Subcommittee beginning at the next meeting. We are accepting all of these recommendations and will present the available requested data at an upcoming meeting of the APC Panel.

B. Policies for Hospital Outpatient Visits

1. Clinic Visits: New and Established Patient Visits

As reflected in Table 39, hospitals use different CPT codes for clinic visits based on whether the patient being treated is a new patient or an established patient. Beginning in CY 2009, we refined the definitions of a new patient and an established patient to reflect whether or not the patient has been registered as an inpatient or outpatient of the hospital within the past 3 years. A patient who has been registered as an inpatient or outpatient of the hospital within the 3 years prior to a visit would be considered to be an established patient for that visit, while a patient who has not been registered as an inpatient or outpatient of the hospital within the 3 years prior to a visit would be considered to be a new patient for that visit. We refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68677 through 68680) for a full discussion of the refined definitions.

We stated in the CY 2010 OPPS/ASC proposed rule (75 FR 46296) that we continue to believe that defining new or established patient status based on whether the patient has been registered as an inpatient or outpatient of the hospital within the 3 years prior to a visit will reduce hospitals' administrative burden associated with reporting appropriate clinic visit CPT codes. For CY 2011, we proposed to continue recognizing the refined definitions of a new patient and an established patient, and applying our policy of calculating median costs for clinic visits under the OPPS using historical hospital claims data. As discussed in section II.A.2.e.(1) of the proposed rule and consistent with our CY 2010 policy, when calculating the median costs for the clinic visit APCs (0604 through 0608), we proposed to continue to utilize our methodology that excludes those claims for visits that are eligible for payment through the extended assessment and management composite APC 8002 (Level I Extended Assessment and Management Composite). We stated in the proposed rule that we continue to believe that this approach results in the most accurate cost estimates for APCs 0604 through 0608 for CY 2011.

Comment: Several commenters recommended that CMS remove the distinction between new and established patient clinic visits, arguing that facilities must expend the same level of resources regardless of whether the patient was registered as an inpatient or an outpatient in the hospital within the past 3 years. Some commenters also asserted that a patient is still "new" the first time he or she receives services at a particular hospital clinic even if the patient has been seen elsewhere in the hospital within the last 3 years. In addition, some commenters stated that there are significant operational issues involved with

implementing the 3-year criterion for hospital clinic visit billing purposes. Some commenters argued that any differences in costs that is evident in claims data for new patient visits versus established patient visits would be the result of hospitals' erroneous reporting of these codes, rather than any real difference in the level of resources expended treating a new versus an established patient.

Many commenters suggested that, as an alternative to the clinic visit CPT codes for new and established patients, hospitals bill for visits based on the resources expended in the visit at a level determined by the hospitals' internal reporting guidelines, regardless of whether the patient is new or established. Some commenters stated that, if CMS chooses to continue to require hospitals to report both new and established patient visit codes, the distinction should be based upon whether the patient has a medical record.

Response: As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60547), because hospital claims data continue to show significant cost differences between new and established patient visits, we continue to believe it is necessary and appropriate to recognize the CPT codes for both new and established patient visits and, in some cases, provide differential payment for new and established patient visits of the same level. For example, the final CY 2011 median cost for the Level 3 new patient clinic visit, described by CPT code 99203 and calculated using over 200,000 single claims from CY 2009, is approximately $101, while the final CY 2011 median cost for the Level 3 established patient clinic visit, described by CPT code 99213 and calculated using over 4.8 million single claims from CY 2009, is approximately $76. We believe this difference in median costs warrants continued assignment of these CPT codes to different APCs for CY 2011.

Given that we have a substantial volume of single claims from a significant number of hospitals upon which to calculate the median costs for all levels of clinic visits, we do not agree with the commenters that the differences in costs for new versus established patient visits are flawed. We expect hospitals to report all HCPCS codes in accordance with correct coding principles, CPT code descriptions, and relevant CMS guidance, which, in this case, specifies that the meanings of "new" and "established" patients as included in the clinic visit CPT code descriptors pertain to whether or not the patient has been registered as an inpatient or an outpatient of the hospital within the past 3 years (73 FR 68679). As we have stated in the past (74 FR 60547), we have no reason to believe that hospitals are systematically disregarding these principles to the extent that our median costs for clinic visits, which are based on data from millions of single claims, would be artificially skewed.

As we stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68678), with respect to a patient being new the first time he or she receives services at a particular hospital clinic even if the patient has been seen elsewhere in the hospital within the last 3 years, we believe this approach could be problematic because we do not believe that every clinic has clear administrative boundaries that define whether the patient was previously seen in that particular clinic. We also note that, as we have stated in the past (73 FR 68678) concerning commenters' request that the distinction between new and established patients be based upon whether the patient has a medical record, we continue to believe it is appropriate to include a time limit when determining whether a patient is new or established because we would expect that care of a patient who was not treated at the hospital for several years prior to a visit could require significantly greater hospital resources than care for a patient who was recently treated at the hospital.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to continue to define new or established patient status for the purpose of reporting the clinic visit CPT codes, on the basis of whether or not the patient has been registered as an inpatient or outpatient of the hospital within the past 3 years. We also are finalizing our CY 2011 proposal, without modification, to continue our policy of calculating median costs for clinic visits under the OPPS using historical hospital claims data. As discussed in detail in section II.A.2.e.(1) of this final rule with comment period and consistent with our CY 2010 policy, when calculating the median costs for the clinic visit APCs (0604 through 0608), we utilized our methodology that excludes those claims for visits that are eligible for payment through the extended assessment and management composite APC 8002 (Level I Extended Assessment and Management Composite). We continue to believe that this approach results in the most accurate cost estimates for APCs 0604 through 0608 for CY 2011.

2. Emergency Department Visits

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

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68132), we finalized the definition of a Type A emergency department to distinguish it from a Type B emergency department. A Type A emergency department must be available to provide services 24 hours a day, 7 days a week, and meet one or both of the following requirements related to the EMTALA definition of a dedicated emergency department specified at 42 CFR 489.24(b), specifically: (1) It is licensed by the State in which it is located under the applicable State law as an emergency room or emergency department; or (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. For CY 2007 (71 FR 68140), we assigned the five CPT E/M emergency department visit codes for services provided in Type A emergency departments to five created Emergency Visit APCs, specifically APC 0609 (Level 1 Emergency Visits), APC 0613 (Level 2 Emergency Visits), APC 0614 (Level 3 Emergency Visits), APC 0615 (Level 4 Emergency Visits), and APC 0616 (Level 5 Emergency Visits). We defined a Type B emergency department as any dedicated emergency department that incurred EMTALA obligations but did not meet the CPT definition of an emergency department. For example, a hospital department that may be characterized as a Type B emergency department would meet the definition of a dedicated emergency department but may not be available 24 hours a day,

7 days a week. Hospitals with such dedicated emergency departments incur EMTALA obligations with respect to an individual who presents to the department and requests, or has a request made on his or her behalf, examination or treatment for a medical condition.

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

As we noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68681), the CY 2007 claims data used for that rulemaking were from the first year of claims data available for analysis that included hospitals' cost data for these new Type B emergency department HCPCS visit codes. Based on our analysis of the CY 2007 claims data, we confirmed that the median costs of Type B emergency department visits were less than the median costs of Type A emergency department visits for all but the level 5 visit. In other words, the median costs from the CY 2007 hospital claims represented real differences in the hospital resource costs for the same level of visits in a Type A or Type B emergency department. Therefore, for CY 2009, we adopted the August 2008 APC Panel recommendation to assign Levels 1 through 4 Type B emergency department visits to their own APCs and to assign the Level 5 Type B emergency department visit to the same APC as the Level 5 Type A emergency department visit.

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

As we noted in the CY 2011 OPPS/ASC proposed rule (75 FR 46297), based on the CY 2009 claims data available for the proposed rule, we note that the pattern of relative cost differences between Type A and Type B emergency department visits is consistent with the distributions we observed in the CY 2008 claims data, as demonstrated in Table 32 of the proposed rule. Therefore, we proposed to continue to pay for Type B emergency department visits in CY 2011 based on their median costs through five levels of APCs: APC 0626 (Level 1 Type B Emergency Department Visit), APC 0627 (Level 2 Type B Emergency Department Visit), APC 0628 (Level 3 Type B Emergency Department Visit), APC 0629 (Level 4 Type B Emergency Department Visit), and APC 0630. We stated that we continue to believe that this configuration pays appropriately for each level of Type B emergency department visits based on estimated resource costs from more recent claims data. We also noted that, as discussed in section II.A.2.e.(1) of the proposed rule and consistent with our CY 2010 policy, when calculating the median costs for the emergency department visit and critical care APCs (0609 through 0617 and 0626 through 0630), we proposed to utilize our methodology that excludes those claims for visits that are eligible for payment through the extended assessment and management composite APC 8002. We stated that we believe that this approach will result in the most accurate cost estimates for APCs 0604 through 0608 for CY 2011.

Comment: One commenter requested clarification regarding "triage only" visits in which a patient is seen by a nurse and triaged in the hospital emergency department but leaves prior to a physician's examination and treatment. The commenter asked if hospitals can bill visit codes for such cases when facility resources are incurred if the patient is not seen by a physician.

Response: As we have stated in the past (73 FR 68686 and 74 FR 60551), under the OPPS, unless indicated otherwise, we do not specify the type of hospital staff (for example, nurses or pharmacists) who may provide services in hospitals because the OPPS only makes payment for services provided incident to physicians' services. Hospitals providing services incident to physicians' services may choose a variety of staffing configurations to provide those services, taking into account other relevant factors, including State and local laws, hospital policies, and other Federal requirements such as EMTALA and the Medicare conditions of participation related to hospital staffing. Billing a visit code in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate. A hospital may bill a visit code based on the hospital's own coding guidelines which must reasonably relate the intensity of hospital resources to different levels of HCPCS codes. Services furnished must be medically necessary and documented.

After consideration of the public comments we received, we are adopting our proposal, without modification, to continue paying for Type B emergency department visits in CY 2011, consistent with their median costs through 5 levels of Type B emergency department visit APCs: APC 0626 (Level 1 Type B Emergency Visits), APC 0627 (Level 2 Type B Emergency Visits), APC 0628 (Level 3 Type B Emergency Visits), APC 0629 (Level 4 Type B Emergency Visits), and APC 0630 (Level 5 Type B Emergency Visits). We are assigning HCPCS codes G0380, G0381, G0382, G0383, and G0384 (the levels 1, 2, 3, 4, and 5 Type B emergency department visit Level II HCPCS codes) to APCs 0626, 0627, 0628, 0629, and 0630, respectively, for CY 2011. We continue to believe that this configuration pays appropriately for each level of Type B emergency department visits based on

estimated resource costs from the most recent claims data.

We also note that, as discussed in section II.A.2.e.(1) of this final rule with comment period and consistent with our CY 2010 policy, when calculating the median costs for the emergency department visit and critical care APCs (0609 through 0617 and 0626 through 0630), we utilized our methodology that excludes those claims for visits that are eligible for payment through the extended assessment and management composite APC 8002 (Level I Extended Assessment and Management Composite). We continue to believe that this approach will result in the most accurate cost estimates for APCs 0604 through 0608 for CY 2011.

Table 40 below displays the median costs for each level of Type B emergency department visit APCs under the final CY 2011 configuration, compared to the final median costs for each level of clinic visit APCs and each level of Type A emergency department visit APCs.

TABLE 40—COMPARISON OF MEDIAN COSTS FOR CLINIC VISIT APCS, TYPE B EMERGENCY DEPARTMENT VISIT APCS, AND TYPE A EMERGENCY DEPARTMENT VISIT APCS

Visit level	CY 2011 clinic visit approximate APC median cost	CY 2011 type B emergency department approximate APC median cost	CY 2011 type A emergency visit approximate APC median cost
Level 1	$52	$41	$51
Level 2	74	59	86
Level 3	99	100	138
Level 4	127	164	220
Level 5	167	270	326

For CY 2010 and in prior years, The AMA CPT Editorial Panel has defined critical care CPT codes 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes) and 99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)) to include a wide range of ancillary services such as electrocardiograms, chest X-rays and pulse oximetry. As we have stated in manual instruction, we expect hospitals to report in accordance with CPT guidance unless we instruct otherwise. For critical care in particular, we have instructed hospitals that any services that the CPT Editorial Panel indicates are included in the reporting of CPT code 99291 (including those services that would otherwise be reported by and paid to hospitals using any of the CPT codes specified by the CPT Editorial Panel) should not be billed separately. Instead, hospitals should report charges for any services provided as part of the critical care services. In establishing payment rates for critical care services, and other services, CMS packages the costs of certain items and services separately reported by HCPCS codes into payment for critical care services and other services, according to the standard OPPS methodology for packaging costs (Medicare Claims Processing Manual (Pub. L. 100–04), Chapter 4, Section 160.1).

For CY 2011, the AMA CPT Editorial Panel is revising its guidance for the critical care codes to specifically state that, for hospital reporting purposes, critical care codes do not include the specified ancillary services. Beginning in CY 2011, hospitals that report in accordance with the CPT guidelines will begin reporting all of the ancillary services and their associated charges separately when they are provided in conjunction with critical care. Because the CY 2011 payment rate for critical care services is based on hospital claims data from CY 2009, during which time hospitals would have reported charges for any ancillary services provided as part of the critical care services, we believe it is inappropriate to pay separately in CY 2011 for the ancillary services that hospitals may now report in addition to critical care services. Therefore, for CY 2011, we will continue to recognize the existing CPT codes for critical care services and are establishing a payment rate based on our historical data, into which the cost of the ancillary services is intrinsically packaged, and we will implement claims processing edits that will conditionally package payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment. The payment status of the ancillary services will not change when they are not provided in conjunction with critical care services.

Our treatment of the revised CY 2011 critical care codes is open to public comment for 60 days following issuance of this final rule with comment period, and we will respond to the comments in the CY 2012 final rule with comment period. We are assigning status indicator "Q3" (Codes That May Be Paid Through a Composite APC) to the ancillary services to indicate that payment for them is packaged into a single payment for specific combinations of services and made through a separate APC payment or packaged in all other circumstances, in accordance with the OPPS payment status indicated for status indicator "Q3" in Addendum D1 to this final rule with comment period. The ancillary services that were included in the definition of critical care prior to CY 2011 and that will be conditionally packaged into the payment for critical care services when provided on the same date of service as critical care services in CY 2011 are listed in Addendum M to this final rule with comment period.

3. Visit Reporting Guidelines

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

As noted in detail in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66802 through 66805), we observed a normal and stable distribution of clinic and emergency department visit levels in hospital claims over the past several years. The data indicated that hospitals, on

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

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

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

Comment: Several commenters expressed appreciation for CMS' approach of studying the challenges associated with national guidelines prior to their implementation. One commenter indicated that, while a standardized coding methodology adopted by CMS would be ideal, it would be preferable for CMS to replace the existing visit CPT codes with hospital-specific HCPCS codes rather than require hospitals to adapt to national guidelines, because providers are now accustomed to using their own guidelines.

Several commenters urged CMS to move forward with the implementation of national guidelines for hospitals to report clinic visits, citing a need for standardization and consistency in the definition and reporting of facility resource utilization and the challenges of having different guidelines in place by different payers. Other commenters asserted that variations in hospitals' internal guidelines may result in inconsistent cost data upon which payment rates for visits are based, and that the use of hospital-specific internal guidelines is contrary to government and industry goals of data uniformity, consistency, and comparability. Some commenters noted that some Medicare contractors use their own auditing methods rather than reviewing each hospital's internal guidelines while conducting medical reviews, putting hospitals at an increased risk during audits or fraud investigations.

Several commenters also recommended that, in the absence of national guidelines for hospital visit reporting, CMS support a request to the American Medical Association CPT Editorial Panel to create unique CPT codes for hospital reporting of ED and clinic visits based on internally developed guidelines. Some commenters also recommended that CMS take a fresh look at approaches for adopting national visit guidelines by carefully reevaluating proposals that have been submitted in the past, as well as evaluating different sets of hospital-developed internal guidelines that appear to be working well. According to the commenters, the national guidelines should be clear, concise, and specific with little or no room for varying interpretations, and hospitals should have at least 1 year to prepare for the transition. One commenter recommended 12 to18 months lead time in the issuance of national guidelines in order to allow facilities sufficient time for education and the process of converting their existing system to the national standard.

Response: As we have in the past (74 FR 60553), we acknowledge that it would be desirable to many hospitals to have national guidelines. However, we also understand that it would be disruptive and administratively burdensome to other hospitals that have successfully adopted internal guidelines to implement any new set of national guidelines while we address the problems that would be inevitable in the case of any new set of guidelines that would be applied by thousands of hospitals. We will continue to regularly reevaluate patterns of hospital outpatient visit reporting at varying levels of disaggregation below the national level to ensure that hospitals continue to bill appropriately and differentially for these services. We

reiterate our expectation that hospitals' internal guidelines fully comply with the principles listed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 68805). As noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66806), we encourage fiscal intermediaries and MACs to review a hospital's internal guidelines when an audit occurs. While we also would encourage RACs to review a hospital's internal guidelines when an audit occurs, we note that currently there are no RAC activities involving visit services. RAC audits may involve CMS-approved issues only and must be posted to each RAC's Web site.

We agree with the commenters that national guidelines should be clear, concise, and specific with little or no room for varying interpretations, and that hospitals should have at least 1 year to prepare for the transition. If the AMA were to create facility-specific CPT codes for reporting visits provided in HOPDs, we would certainly consider such codes for OPPS use.

We appreciate all of the comments we have received in the past from the public on visit guidelines, and we encourage continued submission of comments throughout the year that would assist us and other stakeholders interested in the development of national guidelines. Until national guidelines are established, hospitals should continue using their own internal guidelines to determine the appropriate reporting of different levels of clinic and emergency department visits. While we understand the interest of some hospitals in having us move quickly to promulgate national guidelines that would ensure standardized reporting of hospital outpatient visit levels, we believe that the issues and concerns identified both by us and others are important and require serious consideration prior to the implementation of national guidelines. Because of our commitment to provide hospitals with 6 to 12 months notice prior to implementation of national guidelines, we would not implement national guidelines prior to CY 2012. Our goal is to ensure that OPPS national or hospital-specific visit guidelines continue to facilitate consistent and accurate reporting of hospital outpatient visits in a manner that is resource-based and supportive of appropriate OPPS payments for the efficient and effective provision of visits in hospital outpatient settings.

X. Payment for Partial Hospitalization Services

A. Background

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

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

Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the OPD services to be covered under the OPPS. The existing Medicare regulations at 42 CFR 419.21 that implement this provision specify that payments under the OPPS will be made for partial hospitalization services furnished by CMHCs as well as those services furnished by hospitals to their outpatients. Section 1833(t)(2)(C) of the Act requires the Secretary to establish relative payment weights for covered OPD services (and any APCs) based on median (or mean, at the election of the Secretary) hospital costs using data on claims from 1996 and data from the most recent available cost reports. Section 1833(t)(9)(A) of the Act requires the Secretary to "review not less often than annually and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors." Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APCs, effective for services furnished on or after August 1, 2000 (65 FR 18452 through 18455).

From CY 2003 through CY 2006, the median per diem cost for CMHCs fluctuated significantly from year to year, while the median per diem cost for hospital-based PHPs remained relatively constant. We believe that CMHCs may have increased and decreased their charges in response to Medicare payment policies.

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

In CY 2009, we implemented several regulatory, policy, and payment changes, including a two-tiered payment approach for PHP services under which we pay one amount for days with 3 services (APC 0172 (Level I Partial Hospitalization)) and a higher amount for days with 4 or more services (APC 0173 (Level II Partial Hospitalization)). We refer readers to section X.C.2. of the CY 2009 OPPS/ASC final rule with comment period (73 FR 68688 through 68693) for a full discussion of the two-tiered payment system. In addition, for CY 2009, we finalized our policy to deny payment for any PHP claims for days when fewer than 3 units of therapeutic services are provided. As noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68694), we believe that 3 services should be the minimum

number of services allowed in a PHP day because a day with 1 or 2 services does not meet the statutory intent of a PHP. We continue to believe that the minimum threshold of three services is appropriate because it takes into consideration unforeseen circumstances, such as medical appointments, while maintaining the integrity of the PHP benefit.

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

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

B. PHP APC Update for CY 2011

To develop proposed payment rates for the CY 2011 OPPS/ASC proposed rule (75 FR 46299), we used CY 2009 claims data and computed median per diem costs in the following categories: (1) All days; (2) days with 3 services; and (3) days with 4 or more services. These proposed median per diem costs were computed separately for CMHC PHPs and hospital-based PHPs and are shown in Table 41 below.

TABLE 41—PROPOSED PHP MEDIAN PER DIEM COSTS FOR CMHC AND HOSPITAL-BASED PHPS, BY CATEGORY, BASED ON CY 2009 CLAIMS DATA

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

Using CY 2009 claims data and the refined methodology for computing PHP per diem costs that we adopted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66672), we computed a median per diem cost from all claims for CY 2011 of $132.28. As stated in the CY 2011 OPPS/ASC proposed rule (75 FR 46299), the data indicate that, although CMHCs provided more days with 4 or more services in CY 2009 than in CY 2008, their median per diem cost for 4 or more services ($123.35) is substantially lower than the median per diem cost for the same units of service provided in hospital-based PHPs ($235.58). The median per diem cost for claims containing 4 or more services for all PHP claims, regardless of site of service, is $131.56. The median per diem costs for claims containing 3 services are $118.19 for CMHC PHPs and $184.47 for hospital-based PHPs, and $140.96 for all PHP service claims, regardless of site of service.

We stated in the CY 2011 OPPS/ASC proposed rule that these data, along with data from previous years, show the shift in cost and utilization for CMHCs and hospital-based PHPs under the two-tiered payment system (75 FR 46299 through 46300). Since CY 2009 (using 2007 data), we noted that CMHCs' costs decreased from $139 in CY 2009 to $118 in CY 2011 for Level I services (3 services) and from $172 in CY 2009 to $123 in CY 2011 for Level II services (4 or more services). For hospital-based PHPs, costs increased from $157 in CY 2009 (using 2007 data) to $184 in CY 2011 for Level I services (3 services) and from $200 in CY 2009 to $236 in CY 2011 for Level II services (4 or more services). We stated that, for the past 2 years, we have based the PHP APC per diem payment rates on only hospital-based PHP data because including the CMHC data would have lowered the PHP APC per diem rates and raised concerns about appropriate payment for PHP services. Specifically, we stated that we were concerned about paying hospital-based PHP programs a rate that is lower than what their cost structure reflects, which in turn could lead to hospital-based program closures and possible access problems for Medicare beneficiaries. We also stated that we were concerned about further reducing the payment rates without knowing the impact of the policy and payment changes we made in CY 2009.

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

In the CY 2011 OPPS/ASC proposed rule (75 FR 46300), we proposed to compute four separate PHP APC per diem payment rates, two for CMHC PHPs (for Level I and Level II services using only CMHC data) and two for hospital-based PHPs (Level I and Level II services using only hospital-based PHP data). Creating the four proposed payment rates (two for CMHC PHPs and two for hospital-based PHPs) would support continued access to the PHP benefit, including a more intensive level of care, while also providing appropriate payment based on the unique cost structures of CMHC PHPs and hospital-based PHPs. We proposed the following APC median per diem costs for PHP services for CY 2011:

TABLE 42—PROPOSED CY 2011 MEDIAN PER DIEM COSTS FOR CMHC PHP SERVICES

Proposed APC	Group title	Proposed median per diem costs
0172	Level I Partial Hospitalization (3 services) for CMHCs	$118.19
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	123.35

TABLE 43—PROPOSED CY 2011 MEDIAN PER DIEM COSTS FOR HOSPITAL-BASED PHP SERVICES

Proposed APC	Group title	Proposed median per diem costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	$184.47
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	235.58

We noted in the CY 2011 OPPS/ASC proposed rule (75 FR 46300) that this proposed policy is consistent with the recommendation made by several commenters in the CY 2010 OPPS/ASC final rule with comment period that urged CMS to adopt two additional payment rates that are site-specific APCs for PHP services, where the hospital-based PHP APCs for Level I services (3 services) and Level II services (4 or more services) would be established using only hospital-based data and the CMHC PHP APCs for Level I services (3 services) and Level II services (4 or more services) would be established using only CMHC data (74 FR 60557).

We requested public comments on our proposal to provide four separate PHP APC per diem payment rates, two for CMHC PHPs and two for hospital-based PHPs. We received numerous public comments in response to our proposal. A summary of the comments received and our responses follow:

Comment: Several commenters representing hospital-based PHPs supported CMS' proposal to establish four separate PHP APC per diem payment rates, two for CMHCs (using CMHC data only) and two for hospital-based PHPs (using hospital-based data only). However, these commenters urged CMS to consider transitioning the CMHC reduction in payment over 2 to 3 years to prevent possible CMHC closures.

Several commenters representing CMHCs also expressed their concern that a single large reduction in payment, without a mitigating transition, may result in CMHC closures and may limit access to mental health services to an already vulnerable population. A few of the commenters further stated that CMHC closures, especially in rural areas, may result in mentally ill individuals ending up homeless, in jail, or in emergency rooms. A couple of commenters also pointed out that CMHCs located in the Gulf region are also dealing with the oil spill and its devastating impact on communities.

Several commenters representing CMHCs also urged CMS to reconsider its proposed exclusion of hospital costs from the calculation of APC rates for partial hospitalization services furnished by CMHCs. The commenters stated that excluding hospital costs from the calculation is contrary to section 1833(t)(2)(C) of the Act and correlating regulation 42 CFR 419.31(b)(1).

A few commenters suggested that CMS freeze PHP rates for CMHCs at the CY 2010 levels. These commenters stated that freezing the rates would allow CMHCs time to assess the impact of the rate reduction and section 1301(a) of HCERA 2010 on their operations. These commenters also expressed concern that moving forward with the proposed rate reduction could cause potential CMHC closures.

A couple of commenters also stated that the proposed changes in the CY 2011 OPPS/ASC proposed rule do not support the Patient Protection and Affordable Care Act and the Mental Health Parity and Addiction Equity Act of 2008.

Response: We appreciate the commenters who supported our proposal to create four separate PHP APC per diem payment rates, two for CMHC PHPs (using only CMHC data) and two for hospital-based PHPs (using only hospital-based PHP data). We understand commenters' concerns about the proposed CMHC per diem rate reduction and the impact the reduction may have on access to the PHP benefit in both provider settings. However, we also believe that we can no longer ignore the different cost structures of CMHCs and hospital-based PHPs. As we discussed earlier in this section, CMHCs' costs have fluctuated significantly and then declined over the years. Conversely, the hospital-based PHP costs have been relatively stable since the inception of the OPPS. Furthermore, in the past, we have provided different measures to control the CMHC cost fluctuation in order to protect access to care and with the hope that the cost structures for both provider types would eventually become more consistent. However, after several years of generally paying CMHCs relatively more than their cost data, while at times generally paying hospital-based PHPs relatively less than their cost data, we conclude that we need to create more appropriate payments that reflect the cost structure of each provider type. Section 1833(t)(9)(A) of the Act requires the Secretary to "review not less often than annually and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors." We believe that we have authority to revise the groups and relative payment weights and to make other adjustments to the payment rates for PHP services, including basing rates on hospital-based PHP data only, combined hospital-based PHP and CMHC data, or CMHC data only, to take into account relevant information and factors that would allow us to more appropriately pay providers for the resource costs associated with providing PHP services. Therefore, we are finalizing the four separate PHP APC per diem payment rates, two for CMHC PHPs (for Level I and Level II services using only CMHC data) and two for hospital-based PHPs (for Level I and Level II services using only hospital-based PHP data).

Although we are committed to paying providers appropriately, based on cost data, we are just as concerned about protecting access to care. The PHP benefit and mental health services are very important to us. We understand the commenters' concerns that a single large reduction in payment could potentially result in access to care issues in both CMHCs and hospital-based PHPs

because the hospital-based PHPs potentially may need to provide additional services to accommodate those individuals displaced by any potential closures.

After consideration of the public comments we received and for reasons we have discussed, we have decided to provide a 2-year transition to CMHC rates based solely on CMHC data for the two CMHC PHP APC per diem rates. For CY 2011, the CMHC PHP APC Level I and Level II rates will be calculated by taking 50 percent of the difference between the CY 2010 final hospital-based medians and the CY 2011 final CMHC medians and adding that number to the CY 2011 final CMHC medians. We believe a 2-year transition under this methodology will move us in the direction of our goal, which is to pay appropriately for PHP services based on each provider type's cost data, while at the same time allowing providers time to adjust their business operations and to protect access to care for beneficiaries. For CY 2011, the CMHC APC for Level I Partial Hospitalization (3 services) will be calculated by taking 50 percent of the difference between the CY 2010 final hospital-based median for Level I Partial Hospitalization (3 services) and the CY 2011 final CMHC median for Level I Partial Hospitalization (3 services) and adding that number to the CY 2011 final CMHC median for Level I Partial Hospitalization (3 services) or in numerical terms: $148.48 minus $108.01 equals $40.47, then take 50 percent of $40.47, which equals $20.24. The $20.24 amount will be added to the CY 2011 CMHC final Level I Partial Hospitalization (3 services) median of $108.01 to yield $128.25. The CMHC APC for Level II Partial Hospitalization (4 or more services) will be calculated in the same manner, by taking 50 percent of the difference between the CY 2010 final hospital-based median for Level II Partial Hospitalization (4 or more services) and the CY 2011 final CMHC median for Level II Partial Hospitalization (4 or more services) and adding that number to the CY 2011 final CMHC median for Level II Partial Hospitalization (4 or more services) or in numerical terms: $208.96 minus $116.37 equals $92.59, then take 50 percent of $92.59,which equals $46.30. The $46.30 amount will be added to the CY 2011 final CMHC Level II Partial Hospitalization (4 or more services) median of $116.37 to yield $162.67. The CY 2011 CMHC PHP APC Level I (3 services) cost is $128 and the Level II (4 or more services) cost is $163. The CY 2011 hospital-based PHP Level I (3 services) median cost is $203 and the Level II (4 or more services) cost is $236.

For CY 2012, we plan to implement the CMHC per diem rate using only CMHC data. However, we will review and analyze the data during the CY 2012 rulemaking cycle and may, based on these analyses, further refine the payment mechanism.

Finally, in response to the request to freeze the PHP payment rates at CY 2010 levels, we will not adopt this suggestion because we believe that it is most appropriate to pay for PHP services based on the cost data for each provider type, and the CY 2010 payment rates are calculated using only hospital-based data. Further, in response to concern from commenters' that we are not supporting the Patient Protection and Affordable Care Act and the Mental Health Parity and Addiction Equity Act of 2008, we believe that we are in compliance with both Acts and, as discussed in this section and elsewhere, are supportive of mental health.

Comment: Several commenters suggested alternative methodologies for paying PHP providers, such as requesting that CMS form a study group comprised of providers, CMS representatives and members of the APC committee to determine a more accurate reimbursement methodology for providers. One commenter offered to assist in analyzing the methodology, suggesting a methodology based upon a percentage of base rates for inpatient psychiatric daily rates or perhaps unbundling PHP services and base payment on the individual HCPCS codes. One commenter suggested removing PHP from the APC codes and, instead, establishing a separate payment system similar to home health. Other commenters believed that CMS should include non-Medicare reimbursable costs in the ratesetting calculations, such as meals, transportation, 24-hour on call service, community education and screenings for admission to State facilities, operational costs for other outpatient services, as well as case management. A few commenters pointed out that the methodology, although mathematically correct, has not yielded reimbursement rates satisfactory to providers. Several commenters expressed concern that the methodology used reflects many variables that provide for an incorrect cost per day forcing CMHCs to cut costs to stay in business, and produces a lower CCR the following year. A couple of commenters suggested perhaps a GAO true cost analysis to determine fair costing.

Response: Currently, the statute does not provide for a separate or alternative payment system for partial hospitalization services, as requested by commenters, and any significant change in payment methodology would require a statutory change. Also, we would not include non-Medicare reimbursable costs in our calculation of Medicare PHP payments because we do not base Medicare PHP payments on non-Medicare reimbursable costs. Further, section 1861(ff) of the Act, which defines partial hospitalization services, explicitly excludes meals and transportation from the items and services included in partial hospitalization services.

In response to the commenters who find our methodology mathematically correct, but resulting payments unsatisfactory, we believe our methodology to be accurate and the resulting payments to be appropriate. We determine median cost by computing a separate per diem cost for each day rather than for each bill. Under this method, a cost is computed separately for each day of PHP care. When there are multiple days of care entered on a claim, a unique cost is computed for each day of care. In this manner, we can accurately assess and recognize the costs associated with each day of care. All of these costs are then arrayed from lowest to highest and the middle value of the array would be the median per diem cost. We adopted this method of computing PHP per diem median cost because we believe it produces a more accurate estimate because each day gets an equal weight towards computing the median. This method for computing a PHP per diem median cost more accurately reflects the costs of a PHP and uses all available PHP data.

Furthermore, we disagree with the commenters who suggested that our methodology reflects many variables that provide for an incorrect cost per day. We believe that this comment reflects confusion about how the CCRs influence the medians. We disagree that reduction in cost leads to reduction in CCRs. This outcome only occurs if charges remain the same.

We welcome any input and information that the industry can provide about the costs of their programs and encourage providers to submit information on their costs. We also welcome reports on this issue, including a GAO or other cost analyses. We note, however, that we do not direct GAO activities.

Comment: A few commenters requested that CMHC cost report information be included in the Healthcare Cost Report Information System (HCRIS).

Response: We appreciate the commenters' request to make CMHC data available through the HCRIS and starting in early 2011, CMHC cost report information will begin to be available in the HCRIS. The hospital-based PHP data are based on cost report information currently in and accessible through the HCRIS.

Comment: A few commenters expressed their concern as to why CMS continues to state that a day of partial hospitalization should not equal the cost of the separate services provided in a non-PHP setting. They stated that, for example, four individual group psychotherapy services (APC 0325) add up to more than a proposed Level II day of PHP for CMHCs.

Response: We do not believe that it is appropriate to compare the partial hospitalization services to separate mental health services. The payment rates for individual APC services cited by the commenter (APC 0325) are not computed from PHP bills. As stated earlier, we used data from PHPs to determine the median cost of a day of PHP service. A PHP is a program of services where savings can be realized by hospitals and CMHCs over delivering individual psychotherapy services.

We structured the PHP APCs (APCs 0172, 0173, 0175, and 0176) as a per diem methodology in which the day of care is the unit that reflects the structure and scheduling of PHPs and the composition of the PHP APCs consist of the cost of all services provided each day. Although we require that each PHP day include a psychotherapy service, we do not specify the specific mix of other services provided, and our payment methodology reflects the cost per day rather than the cost of each service furnished within the day. We believe the data used for setting the PHP payment appropriately reflect the typical PHP day and its costs should not be compared to the costs of providing separate services. A PHP is a complete program of services with efficiencies and economies of scale provided in contrast to individual psychotherapy services.

In summary, after consideration of the public comments we received, we are finalizing our CY 2011 proposal, with modification, to establish four separate PHP APC per diem payment rates, two for CMHC PHPs and two for hospital-based PHPs, based on each provider's own unique cost data. As discussed above, we are instituting a 2-year transition to CMHC rates based solely on CMHC data for the two CMHC PHP APC per diem payments, which will help mitigate the rate reduction. Specifically, for CY 2011, we are calculating the CMHC PHP APC Level I and Level II rates by taking 50 percent of the difference between the CY 2010 final hospital-based medians and the CY 2011 final CMHC medians and adding that number to the CY 2011 final CMHC medians. The two hospital-based PHP APCs per diem payments are finalized as proposed.

The updated PHP APCs median per diem costs that we are finalizing for CY 2011 are shown in Tables 44 and 45 below:

TABLE 44—CY 2011 MEDIAN PER DIEM COSTS FOR CMHC PHP SERVICES PLUS TRANSITION

APC	Group title	Median per diem costs plus transition
0172	Level I Partial Hospitalization (3 services) for CMHCs	$128.25
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	162.67

TABLE 45—CY 2011 MEDIAN PER DIEM COSTS FOR HOSPITAL–BASED PHP SERVICES

APC	Group title	Median per diem costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	$202.71
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	235.79

C. Changes to Regulations to Incorporate Provisions of HCERA 2010

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

Our existing regulations at 42 CFR 410.2 incorporate the statutory definitions of "Community mental health center (CMHC)" and "Partial hospitalization services." We proposed to revise the definition of a CMHC in § 410.2 to include the additional requirement provided for under the amendment made by section 1301(a) of HCERA 2010. Under existing § 410.2, we define "partial hospitalization services" to mean "a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care and furnishes the services described in § 410.43." We proposed to revise this definition to incorporate the amendment made by section 1301(b) of HCERA 2010 to describe partial hospitalization services as a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care "other than in an individual's home or in an inpatient or residential setting" and furnishes the services described in § 410.43.

Comment: Several of the commenters requested that CMS delay or transition the implementation of the provisions of section 1301(a) of HCERA2010, which amended the current definition for Community Mental Health Centers to require that at least 40 percent of its services be provided to individuals who are not eligible for benefits under this

title. Several commenters requested that CMS provide further guidance on how this provision will be applied. Several commenters expressed concern that a large reduction in Medicare payment, combined with the 40 percent threshold provision, will impact access to care and potentially cause CMHC closures.

Response: We understand the commenters' concerns, but we do not have discretion to provide a transition or to delay the effective date of this provision. CMS' inclusion of the HCERA 2010 statutory language in the CY 2011 OPPS proposed and final rules is to update our regulations to reflect current law. Furthermore, Congress included in this particular provision of the law the specific effective date: "the first day of the first calendar quarter that begins at least 12 months after the date of enactment," that is April 1, 2011. The provision also does not provide for any Secretarial discretion. Therefore, effective April 1, 2011, a CMHC will be required "to provide at least 40 percent of its services to individuals who are not eligible for benefits under Title XVIII of the Act" (Medicare). CMS will provide further guidance on application of this provision in the coming months.

We did not receive any public comments related to section 1301(b) of HCERA 2010 and, therefore, are finalizing the language as proposed for § 410.2. The revised definition for partial hospitalization specifies that the program must be a distinct and organized intensive ambulatory treatment program offering less than 24-hour daily care "other than in an individual's home or in an inpatient or residential setting."

D. Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469 through 63470), we indicated that, given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. Prior to that time, there was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP services. In addition, further analysis indicated that using the same OPPS outlier threshold for both hospitals and CMHCs did not limit outlier payments to high-cost cases and resulted in excessive outlier payments to CMHCs. Therefore, beginning in CY 2004, we established a separate outlier threshold for CMHCs. The separate outlier threshold for CMHCs has resulted in more commensurate outlier payments.

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

As noted in section II.F. of this final rule with comment period, we proposed to continue our policy of identifying 1.0 percent of the aggregate total payments under the OPPS for outlier payments for CY 2011. We proposed that a portion of that 1.0 percent, an amount equal to 0.04 percent of outlier payments (or 0.0004) percent of total OPPS payments, would be allocated to CMHCs for PHP outlier payments. As discussed in section II.F. of this final rule with comment period, we proposed to set a dollar threshold in addition to an APC multiplier threshold for OPPS outlier payments. However, because the PHP APCs are the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we did not propose to set a dollar threshold for CMHC outlier payments. As noted in section II.F. of this final rule with comment period, we proposed to set the outlier threshold for CMHCs for CY 2011 at 3.40 times the APC payment amount and the CY 2011 outlier payment percentage applicable to costs in excess of the threshold at 50 percent. Specifically, we proposed to establish that if a CMHC's cost for partial hospitalization services, paid under either APC 0172 or APC 0173, exceeds 3.40 times the payment for APC 0173, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate.

Comment: A couple of commenters stated that none of the programs that they worked with receive outlier payments and have not for several years. The commenters suggested that if outlier payments to CMHCs are an issue that CMS discontinue the outlier payment policy.

Response: We are unsure what the commenters mean, but to the extent that commenters suggest that we discontinue outlier payments for CMHCs, we note that we are required to provide outlier payments in accordance with the statute and regulations. In accordance with the requirements set forth in section 1833(t)(5) of the Act and the applicable regulations, the Secretary shall provide for outlier payments under specific circumstances. Under § 419.43(d) of the regulations, subject to paragraph (d)(4) of this section, CMS provides for an additional payment for a hospital outpatient service (or group of services) not excluded under paragraph (f) of this section for which a hospital's charges, adjusted to cost, exceed the following: (i) A fixed multiple of the sum of the applicable Medicare hospital outpatient payment amount determined under § 419.32(c), as adjusted under paragraph § 419.43 (other than for adjustments under this paragraph (d) or paragraph (e) of this section); and any transitional pass-through payment under § 419.66; and (ii) at the option of CMS, a fixed dollar amount. Because CMHCs are a provider of PHP services, which are a type of covered OPD service, outlier payments must be provided for them in accordance with the statute and regulations.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal to set a separate outlier threshold for CMHCs. As discussed in section II.F. of this final rule with comment period, using more recent data for this final rule with comment period, we set the target for hospital outpatient outlier payments at 0.86 percent of total estimated OPPS payments. We allocated a portion of that 0.86 percent, an amount equal to 0.02 percent of outlier payments or 0.0002 percent of total estimated OPPS payments to CMHCs for PHP outlier payments. For CY 2011, as proposed, we are setting the outlier threshold at 3.40 multiplied by the APC payment amount and CY 2011 outlier percentage applicable to costs in excess of the threshold at 50 percent.

XI. Procedures That Will Be Paid Only as Inpatient Procedures

A. Background

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. Before implementation of the OPPS in August 2000, Medicare paid reasonable costs for services provided in the HOPD. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in our regulations those services that were appropriate to

provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

In the April 7, 2000 final rule with comment period (65 FR 18455), we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS. These procedures comprise what is referred to as the "inpatient list." The inpatient list specifies those services for which the hospital will be paid only when provided in the inpatient setting because of the nature of the procedure, the underlying physical condition of the patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. As we discussed in that rule and in the November 30, 2001 final rule with comment period (66 FR 59856), we may use any of a number of criteria we have specified when reviewing procedures to determine whether or not they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS when provided in the hospital outpatient setting. Those criteria include the following:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule with comment period (67 FR 66741), we added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- A determination is made that the procedure is being performed in numerous hospitals on an outpatient basis; or
- A determination is made that the procedure can be appropriately and safely performed in an ASC, and is on the list of approved ASC procedures or has been proposed by us for addition to the ASC list.

The list of codes that will be paid by Medicare in CY 2011 only as inpatient procedures is included as Addendum E to this final rule with comment period.

B. Changes to the Inpatient List

In the CY 2011 OPPS/ASC proposed rule (75 FR 46301), we proposed to use the same methodology for the CY 2011 OPPS as described in the November 15, 2004 final rule with comment period (69 FR 65835) to identify a subset of procedures currently on the inpatient list that are being performed a significant amount of the time on an outpatient basis. Using this methodology, we identified three procedures that met the criteria for potential removal from the inpatient list. We then clinically reviewed these three potential procedures for possible removal from the inpatient list and found them to be appropriate candidates for removal from the inpatient list. During the February 2010 meeting of the APC Panel, we solicited the APC Panel's input on the appropriateness of removing the following three procedures from the CY 2011 inpatient list: CPT codes 21193 (reconstruction of mandibular rami; horizontal, vertical, C, or L osteotomy; without bone graft); 21395 (open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)); and 25909 (amputation, forearm, through radius and ulna; reamputation). Following the discussion at its February 2010 meeting, the APC Panel recommended that CMS remove from the CY 2011 inpatient list the three CPT codes that we had identified: CPT codes 21193, 21395, and 25909.

For the CY 2011 OPPS, we proposed to accept the APC Panel's recommendations to remove the procedures described by CPT codes 21193, 21395, and 25909 from the inpatient list because we agree with the APC Panel that the procedures may be appropriately provided as hospital outpatient procedures for some Medicare beneficiaries.

Comment: Commenters supported the CMS proposal to accept the APC recommendation to remove CPT procedures codes 21193, 21395, and 25909 from the inpatient list.

Response: We appreciated the commenters' support of our proposal.

Comment: Several commenters requested that CMS remove 25 additional codes from the inpatient list based on their own experience, specialty society recommendation, or designation of a procedure as safe in the outpatient setting under one of the many clinical guidelines available, such as *Milliman Care Guidelines.*

Response: We reevaluated the 25 additional procedure codes requested by the commenters using more recent utilization data and further clinical review by CMS medical advisors. These codes are listed in Table 47 below. As a result of the reevaluation, we remain convinced that these procedures could be safely performed only in the inpatient setting.

One of the suggested procedures, CPT code 35045 (direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery), appears to have some volume in the outpatient hospital setting. Therefore, we will present CPT code 35045 to the APC panel at the winter 2011 meeting for the Panel's consideration for removal from the inpatient list.

One commenter provided clinical arguments for a second procedure, CPT code 54650 (Orchiopexy, abdominal approach, for intra-abdominal testis (e.g., Fowler-Stephens), that was low in volume but appeared to be performed some of the time in the outpatient hospital setting. We also will present CPT code 54650 to the APC Panel at the winter 2011 meeting for the panel's consideration for removal from the inpatient list.

Comment: Many commenters suggested that regulations should not supersede the physician's level of knowledge and assessment of the patient's condition, and that the physician can appropriately determine whether a procedure can be performed in a hospital outpatient setting. Other commenters stated that physician's payment should be aligned with the hospital payment; if the hospital is not paid, then the physician payment should not be allowed. They further stated that physicians have little incentive to ensure that inpatient only procedures are performed in the correct setting because their payments are not impacted by an incorrect site of service. One commenter believed that CMS and hospital efforts to educate physicians have not been effective.

Many commenters suggested that the inpatient list be eliminated in its entirety. They indicated that hospitals already meet minimum safety standards through Joint Commission accreditation and the Medicare hospital conditions of participation. Commenters suggested that, if the inpatient list cannot be eliminated in its entirety, an appeals process be developed. Commenters believed that an appeal process would give the hospital the opportunity to submit documentation on the physician's intent, the patient's clinical condition, and the circumstances that enabled the patient to be sent home safely without an inpatient stay. One commenter requested that CMS give its Medicare contractors authority to pay for ancillary services performed with the procedure on the inpatient list if the provider can demonstrate that it could

not have known the physician was going to perform that procedure.

Response: We appreciate these comments and thoughtful suggestions. We continue to believe that the inpatient list is a valuable tool for ensuring that the OPPS only pays for services that can safely be performed in the hospital outpatient setting, and we will not eliminate the inpatient list at this time. We believe that there are many surgical procedures that are never safely performed for a Medicare beneficiary in the hospital outpatient setting. Therefore, it would be inappropriate for us to assign them separately payable status indicators and establish payment rates in the OPPS. We recognize that hospitals already meet minimum safety standards through accreditation or State surveys which assure compliance with the Medicare hospital conditions of participation. However, while accreditation or State survey and certification of compliance with the hospital conditions of participation ensure that a hospital is generally a safe and appropriate environment for providing care, they do not determine whether a particular service can be safely provided in the outpatient setting to Medicare beneficiaries.

Although the commenters suggested that we apply the same payment restrictions to physicians and hospitals when inpatient procedures are performed inappropriately, payment for physicians'services are outside of the scope of the OPPS payment policy and of this OPPS/ASC final rule with comment period. Notwithstanding concern that education has not yet been able to stop some physicians from performing a procedure on the inpatient list in the hospital outpatient setting, we continue to believe that education is critical to ensuring that physicians do not inadvertently provide services in a hospital outpatient setting that only are covered during an inpatient stay. We expect hospitals to be aware of the services that are being provided in the outpatient setting. Hence, we do not believe that it is appropriate to pay the hospital for the ancillary services furnished when the patient receives an inpatient-only service in the hospital outpatient setting. Further, we expect hospitals to use this knowledge and to educate physicians with regard to the appropriate setting for the procedures they furnish. We recognize that there are cases in which the patient expires before he or she can be admitted and has received an inpatient-only service without being admitted. In these cases, we have long made payment for the ancillary services under APC 0375.

As we have stated in the past, we also are concerned about the impact of eliminating the inpatient list on Medicare beneficiary liability. Elimination of the inpatient list might lead to longer time in the hospital outpatient setting, during which Medicare beneficiaries are responsible for copayments for a complex surgery and any individual services supporting that surgery, as well as financial liability for most self-administrable drugs and biological under Medicare Part B. Cost sharing is very different between the hospital inpatient setting and the hospital outpatient setting, and Medicare beneficiaries may incur higher out-of-pocket costs in the hospital outpatient setting for complex surgical procedures. We do not plan to adopt a specific appeals process for claims related to inpatient list procedures performed in the HOPD, and the existing processes established for a beneficiary or a provider to appeal a specific claim remain in effect. We are committed to reviewing the inpatient list timely to reflect changes in medical practice, and we plan to continue our current practice of reviewing procedures for removal from the inpatient list through the public notice-and-comment process.

After consideration of the public comments we received, we are finalizing our proposal without modification. The three procedures that we are removing from the inpatient list for CY 2011 and their CPT codes, long descriptors, and final APC assignments are displayed in Table 46 below.

We are retaining the 25 procedures requested by commenters and reviewed by CMS medical advisors for possible removal from the inpatient list on the inpatient list for CY 2011. These procedures are displayed in Table 47 below. However, two procedures that were requested for removal from the inpatient list by commenters, CPT code 35045 and CPT code 54650, will be presented to the APC Panel at the winter 2011 meeting for the Panel's consideration for removal from the list.

For the complete listing of inpatient only procedures for CY 2011, we refer readers to Addendum E to this final rule.

TABLE 46—PROCEDURES REMOVED FROM THE INPATIENT LIST AND THEIR FINAL APC ASSIGNMENTS FOR CY 2011

CPT code	Long descriptor	CY 2011 APC assignment	CY 2011 status indicator
21193	Reconstruction of mandibular rami; horizontal, vertical, C, or L osteotomy; without bone graft.	0256	T
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft).	0256	T
25909	Amputation, forearm, through radius and ulna; reamputation.	0049	T

TABLE 47—ADDITIONAL PROCEDURES REQUESTED BY COMMENTERS FOR REMOVAL FROM THE INPATIENT LIST FOR CY 2011

CPT code	Long descriptor	CY 2011 status indicator
01214	Anesthesia for open procedures involving hip joint; total hip arthroplasty	C
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty.	C
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement.	C

TABLE 47—ADDITIONAL PROCEDURES REQUESTED BY COMMENTERS FOR REMOVAL FROM THE INPATIENT LIST FOR CY 2011—Continued

CPT code	Long descriptor	CY 2011 status indicator
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes	C
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant	C
20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision). (List separately in addition to code for primary procedure.)	C
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation.	C
21422	Open treatment of palatal or maxillary fracture (LeFort I type)	C
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2.	C
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace. (List separately in addition to code for primary procedure.)	C
22845	Anterior instrumentation; 2 to 3 vertebral segments. (List separately in addition to code for primary procedure.)	C
27557	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair.	C
28800	Amputation of midfoot—Amputation, foot; midtarsal (e.g., Chopart type procedure).	C
35045	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery.	C
37182	Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation).	C
38724	Cervical lymphadenectomy (modified radical neck dissection)	C
39000	Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; cervical approach.	C
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components).	C
54650	Orchiopexy, abdominal approach, for intra-abdominal testis (e.g., Fowler-Stephens).	C
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes.	C
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing.	C
58548	Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed.	C
59856	Induced abortion, by 1 or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation.	C
60270	Thyroidectomy, including substernal thyroid; sternal split of transthoracic approach.	C
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar.	C

XII. OPPS Nonrecurring Technical and Policy Changes and Clarifications

A. Physician Supervision

1. Background

In the CY 2000 OPPS final rule with comment period (65 FR 18524 through 18526), we amended our regulations to establish, as a condition of payment, the requirements for physician supervision of diagnostic and therapeutic services provided to hospital outpatients incident to a physician's service. We adopted physician supervision policies as a condition of payment to ensure that Medicare pays for high quality hospital outpatient services provided to beneficiaries in a safe and effective manner and consistent with Medicare requirements. In the CY 2009 OPPS/ASC proposed rule and final rule with comment period (73 FR 41518 through 41519 and 73 FR 68702 through 68704, respectively), we clarified and restated the various payment requirements for physician supervision of hospital outpatient therapeutic and diagnostic services. In response to concerns about our policy restatement that were expressed following the publication of the CY 2009 final rule with comment period, we met with stakeholders and further delineated our physician supervision policies for both therapeutic and diagnostic services in the CY 2010 OPPS/ASC proposed rule and the final rule with comment period (74 FR 35365 and 74 FR 60679 through 60680, respectively).

While we received and responded to many comments in the course of the CY 2010 rulemaking, addressing supervision for both diagnostic and therapeutic services, it was not until after the publication of the CY 2010 OPPS/ASC final rule with comment period that we received substantial comments from the CAH community in response to a technical correction we made to codify our longstanding view that CAHs are subject to the supervision policy for payment of therapeutic services in the regulations at 42 CFR 410.27. In addition, the broader hospital community continues to indicate that it would prefer that we modify the current supervision policy to permit a lower level of supervision for therapeutic services.

By way of introduction, we have defined supervision in the hospital outpatient setting by drawing on the three levels of supervision that were defined for the physician office setting at § 410.32(b) prior to the OPPS: General, direct, and personal supervision. Over time, we have tailored these definitions to apply them in the hospital outpatient setting, but to date we have maintained the following premises. General supervision means that a service is furnished under the overall direction and control of the physician, but his or her physical presence is not required during the performance of the procedure. Direct supervision means that the physician is physically present on-site and is immediately available to furnish assistance and direction throughout the performance of the procedure; however, the physician does not have to be present in the same room when the procedure is being performed. Personal supervision means the physician is present in the room when the service is being performed.

a. Outpatient Therapeutic Services

As set forth in the CY 2000 OPPS final rule with comment period establishing the hospital outpatient prospective payment system, direct supervision is the current standard for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments (PBDs) of hospitals. In that rule, we defined "direct supervision" to mean that "the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed." The requirement to be "immediately available" was a component of the requirement for direct supervision but we did not define the term at that time.

We clarified that our intention in defining direct supervision for services furnished at a department of a hospital was that a physician be present on the premises of the entity accorded status as a department of the hospital for as long as patients are being treated at that site (65 FR 18525). In that CY 2000 OPPS final rule with comment period, we finalized regulation text in § 410.27(f) specifying that direct supervision is required in PBDs of hospitals, and in the preamble discussion, we emphasized the importance of the direct supervision requirement for off-campus PBDs. We also stated that the language of § 410.27(f) "applies to services furnished at an entity that is located off the campus of a hospital that we designate as having provider-based status as a department of a hospital in accordance with § 413.65." We disagreed with commenters that the requirement for direct supervision in the off-campus PBD was more stringent than the standard we required on the hospital campus. We noted that section 1861(s)(2)(B) of the Act authorizes payment for hospital services provided incident to physicians' services furnished to outpatients. We stated that "we require that hospital services and supplies furnished to outpatients that are incident to physician services be furnished on a physician's order by hospital personnel and under a physician's supervision" (65 FR 18525). We further stated that "we assume the physician supervision requirement is met on hospital premises because staff physicians would always be nearby within the hospital."

In manual guidance, we have clarified that we expect outpatient services incident to physicians' services to be performed under direct supervision. We provide in Section 20.5.1, Chapter 6, of the Medicare Benefit Policy Manual (Pub. L. 100–02) that outpatient services and supplies must be furnished on a physician's order and delivered under supervision. Section 20.5.1 indicates further that each occasion of a service by a nonphysician does not need to also be the occasion of the actual rendition of a personal professional service by the physician responsible for the care of the patient. Nevertheless, as stipulated in that same section of the Manual "during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often enough to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen."

In the CY 2009 OPPS/ASC final rule with comment period, we provided a restatement and clarification of the requirements for physician supervision of hospital outpatient diagnostic and therapeutic services that were set forth in the CY 2000 OPPS final rule with comment period. We chose to restate the existing physician supervision policy for hospital outpatient therapeutic services in part because we were concerned that some stakeholders may have misunderstood our use of the term "assume" in the following statement: "We assume the physician requirement is met on hospital premises because staff physicians would always be nearby within the hospital. The effect of the regulations in this final rule is to extend this assumption to a department of a hospital that is located on the campus of the hospital" (65 FR 18525). We were concerned that stakeholders might believe that this statement meant that we do not require any supervision in the hospital or in an on-campus PBD for hospital outpatient therapeutic services, or that we only require general supervision for those services.

In our policy restatement in the CY 2009 OPPS/ASC final rule with comment period, we reiterated that direct supervision is the standard for physician supervision, as set forth in the CY 2000 OPPS final rule with comment period, for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals as well as in PBDs of hospitals. We stated clearly that we expect direct physician supervision of all hospital outpatient therapeutic services, regardless of their on-campus or off-campus location, but indicated that we would continue to emphasize the physician supervision requirements in off-campus PBDs as we did in the CY 2000 OPPS final rule with comment period. We noted that if there were problems with outpatient care in a hospital or in an on-campus PBD where direct supervision was not in place (that is, the expectation of direct supervision was not met), we would consider that to be a quality concern.

After we published the CY 2009 OPPS/ASC final rule with comment period, we received significantly more public feedback than during the rulemaking cycle about our restatement of our supervision policy for both diagnostic and therapeutic services. We met with stakeholders in the early part of 2009 as we prepared for the CY 2010 rulemaking cycle, as well as reviewed all public input that we received, to craft a response to these concerns regarding the supervision requirements. For therapeutic services, we considered the concerns of various stakeholders

along with our position that direct supervision for therapeutic services is appropriate and aligned with the statutory requirement that Medicare only makes payment for therapeutic services in the hospital outpatient setting that are "incident to" physician services.

In the CY 2010 OPPS/ASC final rule with comment period, we finalized our proposal to allow, in addition to clinical psychologists, certain other nonphysician practitioners to directly supervise services that they may perform themselves under their State license and scope of practice and hospital or CAH-granted privileges. The nonphysician practitioners who were permitted to provide direct supervision of therapeutic services under the CY 2010 OPPS/ASC final rule with comment period are physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, and licensed clinical social workers. These nonphysician practitioners may directly supervise outpatient therapeutic services that they may personally furnish in accordance with State law and all additional requirements, including the Medicare coverage rules relating to their services specified in our regulations at 42 CFR 410.71, 410.73, 410.74, 410.75, 410.76, and 410.77 (for example, requirements for collaboration with, or general supervision by, a physician). In implementing the new benefits for pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation added by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Pub. L. 110–275), we required that direct supervision of services furnished in the hospital outpatient department must be provided by a doctor of medicine or osteopathy as required by statute. The statute does not permit general supervision or supervision by a nonphysician practitioner of PR, CR, or ICR services.

For services furnished on a hospital's main campus, we finalized a modification of our proposed definition of "direct supervision" in new paragraph (a)(1)(iv)(A) of § 410.27 that allowed for the supervisory physician or nonphysician practitioner to be anywhere on the hospital campus. Therefore, as of CY 2010, direct supervision on the hospital or CAH campus or in an on-campus PBD meant that "the supervisory physician or nonphysician practitioner must be present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure." In the CY 2010 OPPS/ASC final rule with comment period, we interpreted "immediate availability" to mean "immediate physical presence" and interruptible (74 FR 60580). We stated that while we had not previously defined "immediately available," we believed that, in the context of the existing definitions of direct supervision in §§ 410.27(f) and 410.32(b)(3)(ii) of the regulations which indicated that the physician must be physically present in PBDs of hospitals or physicians' offices, we had previously established that direct supervision requires immediate physical presence. While we had not specifically defined the word "immediate" for direct supervision in terms of time or distance, we noted that the general definition of the word means "without interval of time." Therefore, the supervisory physician or nonphysician practitioner could not be immediately available while, for example, performing another procedure or service that he or she could not interrupt. In addition, we stated that we understood that advances in medical technology, changes in the patterns of health care delivery, and changes in the organizational structure of hospitals have led to the development of extensive hospital campuses, sometimes spanning several city blocks. However, in the context of direct supervision, we believed that it would not be "immediate" for the supervisory physician or nonphysician practitioner to be so physically far away on the main campus from the location where hospital outpatient services are being furnished that he or she could not intervene right away. In sum, the requirement to be physically present and "immediately available," whether within the hospital or PBD, ultimately determined how far away the supervisory practitioner could be located.

Because the term "in the hospital or CAH" applies broadly to "incident to" requirements such as the site-of-service requirement for therapeutic services provided by the hospital directly and under arrangement, we also established a definition of "in the hospital" in new paragraph § 410.27(g) as meaning areas in the main building(s) of a hospital or CAH that are under the ownership, financial, and administrative control of the hospital or CAH; that are operated as part of the hospital; and for which the hospital bills the services furnished under the hospital's or CAH's CMS Certification Number (CCN). In the preamble to the CY 2010 OPPS/ASC final rule with comment period, as part of the discussion of various public comments on the definition of the hospital campus, and on the supervision requirement specifically, we stated that we would recognize other areas or structures of the hospital's campus that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare to be part of the hospital's campus.

In the CY 2010 OPPS/ASC final rule with comment period, we also finalized our proposal to add paragraph (a)(1)(iv)(B) to § 410.27. This paragraph updated our previous regulation at § 410.27(f) to reflect that, for off-campus PBDs of hospitals, the physician or nonphysician practitioner must be present in the off-campus PBD, as defined in § 413.65, and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or nonphysician practitioner must be in the room when the procedure is performed. In addition, we finalized the proposed technical change to clarify the language in § 410.27(f) by removing the phrase "present and on the premises of the location" and replacing it with the phrase "present in the off-campus provider-based department."

Finally, we finalized a technical correction to the title of § 410.27 to read "Outpatient hospital or CAH services and supplies incident to a physician service: Conditions," to clarify in the title that the requirements for payment of hospital outpatient therapeutic services incident to a physician or nonphysician practitioner service in that section apply to both hospitals and CAHs. Similarly, we included the phrase "hospital or CAH" throughout the text of § 410.27 wherever the text referred only to "hospital." We viewed this as a technical correction because the statute applies the same regulations to hospitals and CAHs when appropriate. Specifically, the definition of "hospital" in section 1861(e) of the Act expressly excludes CAHs "unless the context otherwise requires." Accordingly, we do not believe it is necessary for a payment regulation to reference specifically the applicability to CAHs for those regulations to be appropriate given the "context" for CAHs. Although payment to CAHs is authorized under section 1834(g) of the Act, many of the payment rules applicable to hospitals paid under sections 1886(d) and 1833(t) of the Act apply to CAHs.

We believe that the supervision requirements should apply in the context of CAHs because they represent appropriate safety and quality

requirements for Medicare payment of outpatient services. In the early part of this year, the CAH community asserted that the CAH conditions of participation (CoPs) offer more flexibility in staffing requirements than the rule requiring direct supervision, and that the CAH CoPs address the general availability of physician and nonphysician practitioners on the CAH campus. The hospital CoPs at 42 CFR 482.22 require hospital medical staff to be composed of doctors of medicine or osteopathy and, in accordance with State law, may also be composed of other practitioners appointed by the governing body. They also require 24-hour nursing services that are provided by or supervised by a registered nurse. Under section 1820(c)(2)(B) of the Act, among other criteria, a CAH must meet the same staffing requirements as would apply under section 1861(e) of the Act to a hospital located in a rural area. However, there are some exceptions to these staffing requirements. Section 1820(c)(2)(B)(iv) of the Act specifies that a CAH need not meet hospital staffing requirements under section 1861(e) of the Act regarding the days and hours in which it is open and fully staffed; the facility may provide certain services under arrangement at an off-site location; that inpatient care may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician, who need not be present in the facility.

The CAH CoPs in 42 CFR 485.631 are specific in recognizing the statutory authority to be staffed by nonphysician practitioners rather than physicians, provided a doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates. The requirement that the practitioner "be available" in § 485.631 has been interpreted to mean that the nonphysician practitioner or physician is available by phone, but not necessarily physically present on the CAH campus. The CAH CoPs also specify standards for emergency personnel under § 485.618, requiring that a doctor of medicine or osteopathy, or a nonphysician practitioner such as a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care, be on call and immediately available by telephone or radio contact, and available onsite within 30 minutes, on a 24-hour a day basis in most areas.

However, in the Medicare program, payment requirements are frequently different from those identified in the CoPs because the two sets of rules serve very separate and distinct purposes. CoPs apply largely at the facility level, while payment regulations apply at the service level. Payment regulations, such as requirements for how contracted entities provide services to hospital patients, support program goals of appropriate and accurate payment for quality services. In contrast, for all providers including CAHs, the CoPs authorize hospitals to participate in the Medicare program. We establish CoPs as minimum standards for patient health and safety, and CoPs focus on creating a foundation to ensure quality and safe care for beneficiaries throughout a given facility, irrespective of the payment system or service provided. As previously mentioned, CoPs generally do not apply on the service level and do not ensure that payment is appropriate for specific types of purchased services nor can they substitute for payment requirements since that is not their function.

In summary, requirements established for purposes of payment frequently differ from the requirements established by the CoPs for many providers, including hospitals and CAHs. Whereas payment regulations establish basic parameters defining the services being purchased, CoPs (including both the hospital CoPs and the CAH CoPs) establish standards to ensure a minimum level of quality and safety for operating as a hospital or a CAH. The minimum standards established as CoPs are not always adequate to address the particular quality, safety and other requirements for payment for a service or group of services.

b. Outpatient Diagnostic Services

As we stated in the CY 2009 OPPS/ASC and CY 2000 OPPS proposed rules and final rules with comment period, section 1861(s)(2)(C) of the Act authorizes payment for diagnostic services that are furnished to a hospital outpatient for the purpose of diagnostic study. We have further defined the requirements for diagnostic services furnished to hospital outpatients, including requirements for physician supervision of diagnostic services, in §§ 410.28 and 410.32 of our regulations. In CY 2000, we established in § 410.28(e) that in order to receive payment, outpatient diagnostic services furnished in PBDs of hospitals must be supervised according to the levels assigned for the individual tests as listed in the MPFS Relative Value Unit File. For these services, we also adopted the definitions of general, direct and personal supervision used in the MPFS and delineated in §§ 410.32(b)(3)(i), (b)(3)(ii) and (b)(3)(iii). For CY 2010, we finalized a proposal to extend the rules we had established for PBDs to the hospital setting or any other location where diagnostic services may be provided under arrangement (for example, a nonhospital location such as an independent diagnostic testing facility or IDTF). Where § 410.28(e) had previously only referenced the MPFS supervision requirements for services "furnished at a facility * * * having provider-based status," we broadened the reference to those requirements for "services furnished by or under arrangements made by the participating hospital" and we added further requirements for direct supervision. In the CY 2010 OPPS/ASC rulemaking cycle, in §§ 410.28(e)(1) and (e)(2), we redefined direct supervision for outpatient diagnostic services to mean (with the exception of services provided under arrangement in nonhospital locations) the definition that we adopted at this time for outpatient therapeutic services, specifically that for services furnished directly or under arrangement in the hospital or in the on-campus or off-campus PBD, "direct supervision" means that the physician must be immediately available and present on the same campus or in the off-campus PBD to furnish assistance and direction throughout the performance of the procedure. For purposes of defining direct supervision of diagnostic services, in § 410.28, we applied the definition of "in the hospital" as incorporated in § 410.27(g) for therapeutic services. For diagnostic services furnished under arrangement in nonhospital locations such as an IDTF, in § 410.28(e)(3), we applied the definition of direct supervision used in the MPFS and at § 410.32(b)(3)(ii).

The MPFS Relative Value Unit File is updated quarterly and is available on the CMS Web site at: *http://www.cms.gov/PhysicianFeeSched/*. For diagnostic services not listed in the MPFS Relative Value Unit File, we have indicated that Medicare contractors, in consultation with their medical directors, would define appropriate supervision levels in order to determine whether claims for these services are reasonable and necessary.

We note that the existing requirement in §§ 410.28(e)(1), (e)(2), and (e)(3) that physician supervision of diagnostic services provided by or under arrangements made by the participating hospital or in any PBD follow the levels for diagnostic services established under the MPFS explicitly applies to hospitals that are paid in accordance with to section 1833(t) of the Act, which is the statutory authority for the OPPS.

Because Medicare makes payments to CAHs in accordance with section 1834(g) of the Act, at this time, CAHs are not subject to this supervision requirement.

2. Issues Regarding the Supervision of Hospital Outpatient Services Raised by Hospitals and Other Stakeholders

Following the adoption of our policies in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60575 through 60591), beginning in January 2010, we began to receive a sizable amount of correspondence, as well as numerous phone calls, and questions through other public avenues, including the regular open door forum calls, from the rural hospital and CAH community indicating its belief that the requirement for direct supervision for therapeutic services finalized in that rule is at odds with longstanding and prevailing practice in rural communities. These hospitals and their representatives stated that they generally function with a reduced level of supervision for the provision of therapeutic services and that while they furnish services under a physician's or appropriate nonphysician practitioner's order, frequently no physician or nonphysician practitioner is physically present anywhere in the CAH or small rural hospital while the therapeutic services are being furnished. CAHs, in particular, noted that the provisions in their CoPs allow a CAH to operate under reduced staffing requirements. Specifically, under §§ 485.631 and 485.618 as described above, CAHs must have a physician or one of several types of nonphysician practitioners available by phone at all times, but not on campus. For emergencies, in most areas of the country, the CAH must have a physician or certain other nonphysician practitioners with training or experience in emergency care physically available onsite within 30 minutes.

Both CAHs and rural hospitals have stated that the flexibility to allow nonphysician practitioners to supervise services that we authorized in the CY 2010 OPPS/ASC final rule with comment period is helpful for meeting the direct supervision requirement for all therapeutic services, but that a shortage of qualified practitioners in rural areas continues to make it difficult to staff a physician or nonphysician practitioner for supervision purposes. They also noted that a practitioner retained on the campus of a small rural hospital or CAH to meet supervision requirements may not have other patients or medical activities to complete. In an urban or large urban hospital, a practitioner would be able to see other patients or engage in other activities so long as those activities could be interrupted, such that they would be immediately available to supervise.

In a series of questions and answers about supervision on the CMS Web site (*http://www.cms.gov/HospitalOutpatientPPS/05_OPPSGuidance.asp#TopOfPage*), we provided additional guidance regarding our regulations about who can supervise services in order to explain to CAHs and small rural hospitals the flexibility we believe exists within our requirement for direct supervision. For example, in that document, we state that we believe the emergency physician or the nonphysician practitioner, who would be the most likely practitioners staffing a small rural hospital or CAH, can directly supervise outpatient services so long as the emergency physician or nonphysician practitioner in the emergency department of the campus meets the other requirements of direct supervision. That is, the emergency physician or the nonphysician practitioner needs to be immediately available, so that, if needed, he or she could reasonably be interrupted to furnish assistance and direction in the delivery of therapeutic services provided elsewhere in the hospital. We believe that most emergency physicians and appropriate nonphysician practitioners can supervise many services within the scope of their knowledge, skills, licensure, and hospital-granted privileges, including observation services. With regard to whether an emergency physician or a nonphysician practitioner could be interrupted, such that the individual could be immediately available, we have stated that each hospital would need to assess the level of activity in its emergency department and determine whether at least one emergency physician or nonphysician practitioner could be interrupted to furnish assistance and direction in the treatment of outpatients.

In their correspondence and discussion in public forums, CAHs and small rural hospitals explicitly have raised concerns about services that extend after regular operating hours, especially observation services. They also have asserted that direct supervision is not clinically necessary for some services that have a significant monitoring component that is typically performed by nursing or other auxiliary staff, including IV hydration, blood transfusions, and chemotherapy. They stated that their facilities have protocols to safely deliver all of these services, relying on nursing or other hospital staff to provide the service and having a physician or nonphysician practitioner available by phone to furnish assistance and direction throughout the duration of the therapeutic service.

In the early part of this year, small rural hospitals and CAHs indicated that, regulations notwithstanding, many of them did not have appropriate staff arrangements to provide the required supervision of some services, particularly services being provided after hours or consisting of a significant monitoring component that last for an extended period of time. In response to rising concerns among the rural community about these rules and the inability of some hospitals to meet the direct supervision requirement, we issued a statement on March 15, 2010, indicating that we would not enforce the rules for supervision of hospital outpatient therapeutic procedures furnished in CAHs in CY 2010 (*http://www.cms.gov/HospitalOutpatientPPS/01_overview.asp#TopOfPage*). We also stated that we would proactively revisit the rules surrounding the supervision of services furnished by CAHs in the CY 2011 OPPS/ASC proposed rule.

Compared to supervision of therapeutic services, we have had relatively limited dialogue with stakeholders about our CY 2010 policy to recognize the supervision levels for diagnostic services under the MPFS for the provision of diagnostic services in the hospital. Individual stakeholders have asked about supervision of specific diagnostic services and have noted that our requirement that the hospitals follow the supervision levels for diagnostic services in the hospital identified in the MPFS Relative Value Unit File has required some modest changes in hospital staffing practices. We also have received questions requesting clarification about related supervision requirements for nonphysician practitioners. We note that adopting the supervision levels defined under the MPFS for diagnostic services in 42 CFR 410.32 means that nonphysician practitioners who are not specifically excluded under § 410.32(b) from the level of supervision required by the MPFS are subject to supervision by a physician at the level of supervision required by the diagnostic test. We also discussed in our CY 2010 OPPS/ASC final rule with comment period that diagnostic X-ray and other diagnostic tests must be furnished under the appropriate level of supervision by a physician as defined in section 1861(r) of the Act (74 FR 60588 through 60590).

3. Policies for Supervision of Outpatient Therapeutic Services in Hospitals and CAHs

As indicated in our March 15, 2010 statement, we are revisiting the issue of supervision of outpatient therapeutic services in CAHs to ensure a robust public discussion about supervision requirements for payment in hospital outpatient departments, including those located in rural communities, and CAH outpatient departments. In the CY 2011 OPPS/ASC proposed rule, we proposed modest changes to our supervision policy for therapeutic services that reflect our continuing commitment to require direct supervision for the provision of therapeutic services in the hospital outpatient setting as a requirement for payment (75 FR 46303). We proposed these changes for all hospitals, including CAHs, because we believe that Medicare should purchase a basic quality of service for all Medicare beneficiaries. Specifically, we proposed to identify a limited set of services with a significant monitoring component that can extend for a sizable period of time, that are not surgical, and that typically have a low risk of complication after assessment at the beginning of the service, as "nonsurgical extended duration therapeutic services" (also referred to as "extended duration services"). We listed these services in Table 37 of the proposed rule (75 FR 46308). We proposed for these services that there would be a requirement for direct supervision for the initiation of the service followed by general supervision for the remainder of the service. We proposed to adopt the definition of "general supervision" in existing § 410.32(b)(3)(i), which is the same definition of general supervision that we already recognize as appropriate for diagnostic services with a general supervision level requirement under the MPFS. Finally, at the end of the proposal, we included several discussion points designed to focus public comments and generate sufficient detail to assist us in crafting a final policy.

In considering the significant correspondence from CAHs and rural communities, as well as public discussion on the issue of supervision through the open door forum and calls with individual hospitals and other hospital representatives, we sought to propose modifications to the supervision standards that would balance several countervailing interests. While we sought to identify some means of offering flexibility within the direct supervision requirement and address industry concerns about specific services, we also believed strongly that Medicare should continue to purchase services that are delivered with a basic level of quality and safety and that fulfill the statutory requirement for payment of incident to services. We recognized the concerns of CAHs and rural hospitals that it could be difficult to staff a physician or nonphysician practitioner on the campus to supervise services that have a significant monitoring component and lack an active component being performed by the physician or nonphysician practitioner, especially when these services extend into after business hours or overnight. CAHs and rural hospitals explicitly identified observation services, IV hydration, chemotherapy, and blood transfusions as the services that are particularly challenging to provide under direct supervision. Observation services, in particular, can extend for a significant period of time. Data from the CAH outpatient claims indicate that most observation care lasts longer than 12 hours and that it frequently lasts 24 to 48 hours, suggesting that observation care often extends after business hours and through the night.

We recognized that any service with an extended duration and a significant monitoring component could challenge hospitals' ability to ensure direct supervision, and we decided to concentrate on those services. We set out to identify services with a significant monitoring component extending after business hours as identified by the CAHs and hospitals in rural communities and for which we could offer some flexibility in meeting the requirement for direct supervision of therapeutic services without compromising the quality and safety of services for which Medicare makes payment. One way to provide flexibility would be to allow a reduced level of supervision for part of these services. We established a requirement for direct supervision for all hospital outpatient services in our CY 2000 and CY 2010 rulemaking processes. However, we reasoned that, for certain extended duration services, for CY 2011 we could adopt a general supervision requirement for some portion of the service, as long as we believed that such flexibility would not undermine the quality and safety of purchased services. Therefore, we proposed to require, for a limited set of nonsurgical extended duration therapeutic services, direct supervision during the initiation of the service followed by general supervision for the remainder of the service (75 FR 46306).

We proposed to define "initiation of the service" as the beginning portion of a service ending when the patient is stable and the supervising physician or appropriate nonphysician practitioner believes the remainder of the service can be delivered safely under his or her general direction and control without his or her physical presence on the hospital campus or in the PBD of the hospital. We listed our proposed definition of initiation of the service in proposed § 410.27(a)(1)(v)(B). We considered further defining the term "stable" in this definition as there is an established definition in the Emergency Medical Treatment and Labor Act (EMTALA) regulations at 42 CFR 489.24(b). In those regulations, "stabilized" with respect to an emergency medical condition means "that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer for the individual from a facility * * *" However, this language is set within the context of emergency services, not hospital outpatient therapeutic services generally, and we have been clear that supervision is more than emergency response. Ultimately, we were not certain that this definition would be appropriate for a payment requirement for supervision of outpatient therapeutic services.

We also did not propose to further define the term "initiation" or to set time limits on this portion of the service because we believe that the determination that a patient is sufficiently stable to transfer from direct supervision to general supervision, and the timing of that decision, are clinical judgments. We believed it would be best to leave the determination of when to move from direct to general supervision to the discretion of the supervising physician or nonphysician practitioner. However, we considered whether the point of transfer from direct supervision to general supervision should be documented in the medical record or identified in a hospital protocol, and we invited public comment on how CMS might review the physician or nonphysician practitioner's decision to move from direct to general supervision to monitor for proper billing should an adverse event occur.

We considered four criteria when identifying the list of services to which this new policy of direct supervision during the initiation of the service followed by general supervision for the remainder of the service would apply. We first accepted the two criteria identified in correspondence and discussion with CAHs and rural hospitals, that the service be of extended duration, frequently extending

beyond normal business hours, and that the service largely consist of a significant monitoring component typically conducted by nursing or other auxiliary staff. We added a third criterion that the service must be of sufficiently low risk, such that the service typically would not require direct supervision often during the service. We added this criterion because, as we have previously discussed, our requirement for direct supervision has been grounded in the statutory "incident to" payment authority as well as the need to ensure that Medicare purchases services that represent a basic level of quality and safety. We have noted that, unlike an inpatient admission, the provision of outpatient services lacks certain safeguards such as a detailed medical history and a plan of care (74 FR 60578 through 60588). Finally, we excluded all surgical services including recovery time from potential inclusion because we believed the surgeon should be immediately available during the recovery period. We defined nonsurgical extended duration therapeutic services in proposed regulation text for § 410.27(a)(1)(v)(A).

Using these four criteria, we identified a list of nonsurgical therapeutic services that have a tendency to last for a long period of time, that largely consist of monitoring, and that have a low risk that the physician's physical presence will be needed once the patient is stable. To identify this list of potential services, we reviewed all medical services, including the services and procedures specifically identified by CAHs and rural hospitals in their correspondence and public discussion. The proposed list of nonsurgical extended duration therapeutic services appeared in Table 37 of the proposed rule. We explicitly did not include chemotherapy or blood transfusions in our proposed list of nonsurgical extended duration therapeutic services because we believed that these services would require the physician's or nonphysician practitioner's recurrent physical presence in order to evaluate the patient's condition in the event it is necessary to redirect the service.

We included observation services on the proposed list of nonsurgical extended duration services. In Section 20.6 of Chapter 2 of the Medicare Benefit Policy Manual (Pub. 100–02), we define observation care as "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital." Therefore, the acuity of patients receiving observation services and the amount of recurrent supervisory review that may be necessary for these services can vary significantly. Observation services can be of low acuity and can have a low probability that the supervising physician or nonphysician practitioner's physical presence would be needed to step in and perform the service or otherwise furnish assistance. We noted in Section 290.5.1 of Chapter 4 of the Medicare Claims Processing Manual (Pub. No 100–04) that, among other requirements for observation services, "(a) the beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician," and "(b) the medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care." We stated that we would continue to expect hospitals and CAHs to fulfill these specific requirements associated with observation care, so the supervising physician or appropriate nonphysician practitioner must continue to evaluate the patient periodically and include written notes in the medical record.

In crafting our policy for nonsurgical extended duration therapeutic services, we considered other avenues to offer flexibility within our requirement for direct supervision. We considered and presented the following alternatives in the proposed rule in order to focus public comments and generate sufficient detail to assist us in developing the final policy. Although we reconsidered these alternatives for this final rule, ultimately we did not adopt either of them.

In addition to considering the proposed policy to permit general supervision after an initial period of direct supervision for a limited subset of services, we also considered offering hospitals the flexibility to broaden the list to include chemotherapy and blood transfusions, which some stakeholders also maintain do not require direct supervision. Because we were concerned that these services had a high probability of needing a physician or nonphysician practitioner to redirect the service, we reasoned that under this option, we would have to require hospitals to create internal guidelines specifying a supervision level and protocols for staffing that supervision level for every nonsurgical extended duration therapeutic service. We considered proposing minimum requirements for these internal supervision guidelines, including annual review and approval by a governing committee, periodic internal evaluation of implementation, and the ability to make these guidelines available to Medicare program auditors if requested. Further, these guidelines would be reviewed thoroughly by CMS should a quality issue arise. We did not propose this policy because we believe that an independent entity should evaluate services such as chemotherapy administration and blood transfusion to determine whether or not general supervision is appropriate and safe. In our deliberations on policies for the final rule, we were concerned that this policy would not address many concerns that were brought to our attention by the rural hospital community (shorter duration services and supervision from locations in close proximity to the hospital). We also rejected this alternative because a variable standard of supervision could be administratively difficult for us to audit and evaluate.

We also considered whether for payment purposes we should explicitly or implicitly exclude outpatient therapeutic services provided in CAHs from the requirements for direct supervision. We considered limiting CAHs to their CoPs, which in effect only require them to operate under general supervision. As we stated in the proposed rule, we believe there are strong grounds for applying the same supervision requirements to CAHs as to all other hospital types. One of our grounds for applying the direct supervision requirement to CAHs is that outpatient hospital services are furnished "incident to" physicians' services, and we believe that the incident to rules apply equally to critical access and other types of hospitals. Outpatient hospital services are furnished "incident to" physicians' services under section 1861(s)(2)(B) of the Act and are paid under the OPPS in accordance with section 1833(t) of the Act. In contrast, "outpatient critical access hospital services" are defined under section 1861(mm)(3) of the Act, and CAHs are reimbursed for outpatient CAH services based on their reasonable costs pursuant to section 1834(g) of the Act. We believe that outpatient CAH services are correctly viewed as being furnished "incident to" physicians' services. Section 1861(mm)(3) of the Act defines "outpatient critical access hospital services" as "medical and other

health services furnished by a critical access hospital on an outpatient basis." The term "medical and other health services" is defined at section 1861(s) of the Act as including "hospital services * * * incident to physicians' services rendered to outpatients." Furthermore, the same considerations regarding the need to ensure that services furnished to Medicare beneficiaries represent a basic level of quality and safety that apply to outpatient hospital services are equally applicable to outpatient CAH services. As a result, we believe it is appropriate to apply the same supervision requirements to outpatient therapeutic services furnished in hospitals and CAHs.

We acknowledge that statutory provisions allow CAHs some flexibility in their staffing requirements to operate with more nursing staff and nonphysician practitioners rather than physicians if those are the practitioners that are available, and that our regulations recognize those reduced staffing requirements in the CoPs by establishing that, at a minimum, the physician or nonphysician practitioner must be available within 30 minutes of an emergency. However, as discussed above, we believe that CAHs are subject to payment rules independent of their CoPs. Moreover, some have suggested that the regulations which establish only minimal requirements reduce the quality and safety of CAH services and that CAHs should be required to disclose their reduced staffing levels to patients prior to providing services. We elected not to limit the CAHs to their conditions of participation or to exclude them from direct supervision requirements, because we believe that Medicare should purchase outpatient services from CAHs and other hospitals that are of the same basic level of safety and quality. Also, we believe that both small rural hospitals paid under the OPPS through section 1833(t) of the Act and CAHs paid at reasonable cost under section 1834(g) of the Act have similar staffing and resource constraints. In fact, given that CAHs are reimbursed based on their reasonable costs, in our proposal we reasoned that CAHs might be better able than small rural PPS hospitals to hire staff to provide direct supervision and we did not receive comments as to why this would not be the case.

Comment: Many commenters asserted that there is no evidence of compromised quality of care or patient safety that justifies the new and burdensome change in supervision rules, and that commenters know of no adverse events that have necessitated a change in CMS' supervision policies from general supervision to direct supervision. One commenter suggested that CMS commission an outcomes study to measure a need for direct supervision compared to general supervision in the hospital outpatient department. Many commenters requested that CMS continue to study potential negative effects of enforcing its requirement for direct supervision and that CMS extend the notice indicating that it will not enforce the rules for supervision of hospital outpatient therapeutic procedures furnished in CAHs through CY 2011. Commenters also requested that CMS expand its decision not to enforce the requirement for direct supervision of therapeutic outpatient services in CAHs to other small and rural hospitals that are paid under the OPPS and are located in areas experiencing workforce shortages.

Several commenters asserted that the Act does not prescribe a specific level of supervision for "incident to" physician's services. These commenters believed that CMS has discretion to select an appropriate level of supervision for hospital outpatient "incident to" physician's services other than direct supervision and that the requirement for direct supervision of incident to physician services is technologically outdated. They requested that CMS depart from its historic interpretation of the incident to provision by allowing general supervision for those services. They commented that, for some low-risk and low-complexity services, a physician does not need to be physically present. Many commenters requested that CMS set the minimum standard as general supervision for all services and allow individual facilities to establish other supervision levels for certain services at their discretion. Many commenters also requested that CMS establish an independent panel representative of geographic areas, particularly rural areas, and provider types to identify the appropriate supervision level for individual services.

Response: Our supervision policy is designed to preserve both quality and safety of purchased hospital outpatient services for Medicare beneficiaries. While our recent attention to supervision is not being informed by a specific quality event, we received a substantial number of inquiries from stakeholders prior to 2009 leading us to believe that hospitals were practicing general supervision or no supervision in the provision of services that are paid "incident to" physician's services in the outpatient setting and for which we had established a policy of direct supervision. While literature or clinical opinions may exist on the risk of adverse outcomes and susceptibility to medical error associated with the provision of specific hospital outpatient procedures when a physician is not present, we do not know of any analyses that have directly examined levels of supervision and patient outcomes in the hospital outpatient setting. This may be an area for future study.

We disagree with commenters that our requirement for direct supervision is new or a change from previous policy, and appreciate that several commenters acknowledge that CMS' requirement for direct supervision of hospital outpatient services is not new. One of our longstanding interpretations of the statutory authorization for hospital services "incident to" physicians' services under section 1861(s)(2)(B) of the Act is that these services should be provided under direct supervision. As we have already discussed, we clearly stated in the CY 2000 final rule our regulatory requirement for direct supervision in the off-campus PBD and our presumption that the requirement for direct supervision would be met in the hospital.

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60580), we noted that, prior to 2000, we already required hospitals to meet a direct supervision of "incident to" services requirement for outpatient therapeutic services. That is, we required that hospital services and supplies furnished to outpatients that are incident to physicians' services "must be furnished on a physician's order by hospital personnel and under a physician's supervision" (Section 3112.4 of the Medicare Intermediary Manual). In longstanding manual guidance, we have expressed our historical belief that direct supervision is required for hospital outpatient therapeutic services, and we have suggested that this requirement stems from the "incident to" nature of those services. We have stated in the Medicare Benefit Policy Manual (Pub. No. 100–02), Chapter 6, Section 20.5.2 (revised May 28, 2010) and previously discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60576) that we require direct supervision for the provision of therapeutic services to hospital outpatients: "Therapeutic services and supplies which hospitals provide on an outpatient basis are those services and supplies (including the use of hospital facilities) which are incident to the services of physicians and practitioners in the treatment of patients * * * The services and supplies must be furnished under the order of a physician or other practitioner

practicing within the extent of the Act, the Code of Federal Regulations, and State law, and furnished by hospital personnel under the direct supervision of a physician or nonphysician practitioner as defined at 42 CFR 410.27(f) and 482.12. This does not mean that each occasion of service by a nonphysician need also be the occasion of the actual rendition of a personal professional service by the physician responsible for care of the patient. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen. A hospital service or supply would not be considered incident to a physician's service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of that course of treatment."

With respect to whether CMS has the authority to recognize a supervision level other than direct supervision for payment of "incident to" physician's services under section 1861(s)(2)(B) of the Act, we agree that the statute does not explicitly mandate direct supervision, but we continue to believe that direct supervision is the most appropriate level of supervision for most hospital outpatient services that are authorized for payment "incident to" physician's services. While we believe that the "incident to" authorization permits us to recognize specific circumstances appropriate for general supervision, such as we proposed for extended duration services, we also believe that our historical interpretation of section 1861(s)(2)(B) of the Act, specifically, that these services are furnished under the order of a physician (or nonphysician practitioner), the physician is involved in the management of the patient, and the physician supervises the provision of those services when he or she does not provide them directly, is reflected in a requirement for direct supervision. Therefore, we do not believe it is appropriate to authorize payment for "incident to" services to hospitals with a default supervision level of "general" for all services. In our proposed rule, we focused on extended duration services both because CAHs and small rural hospitals had identified these services as a primary source of their difficulty in complying with our requirement for direct supervision and because we agreed that the monitoring and low risk attributes of the services did not necessarily dictate direct supervision for the entire performance of those services. We also believed that our requirements for "incident to" services (that the physician be involved in the management of the patient and that the services be provided under the physician's supervision) would be met when a period of general supervision followed a period of direct supervision for the initiation of the service.

Comment: In addition to our proposed list of nonsurgical extended duration services (which we are finalizing for this CY 2011 final rule with comment period and discuss in greater detail later in this section), commenters requested that CMS recognize general supervision for many additional services that they considered to be of low risk and low complexity, such as minor surgical procedures, immunization administration, minor wound debridement, group psychotherapy, sleep laboratory services, and patient-controlled anesthesia pumps. One commenter indicated that the organization he represents had convened a physician panel to assess appropriate supervision levels of outpatient services and that the panel found 160 services eligible for general supervision based on a low physician work RVU. Commenters argued that technology has reduced the risk of needing a physician or nonphysician practitioner to furnish assistance and direction during some services.

Response: We agree with commenters that there may be some outpatient services that could be identified as appropriate for general supervision among these and other identified services. However, we are not confident that stakeholders would necessarily agree with our assessment of appropriate supervision levels and we observed through our review of comments that stakeholders did not always agree among themselves about the appropriate supervision level for any given service. For example, we received numerous requests from CAHs and small rural hospitals that we recognize blood transfusions and chemotherapy administration for general supervision, arguing that protocols were in place to handle changes in treatment or emergency situations. However, we also received opposing comments indicating that chemotherapy should not be provided without direct supervision. We note that many of the chemotherapy administration HCPCS codes, like many services, have physician work relative value units associated with them, suggesting that the physician typically would be involved in the provision of these services.

In light of heightened stakeholder interest in supervision requirements, CMS' continuing goal of purchasing safe, quality services that are provided "incident to" a physician's service; and potential disagreement among commenters regarding appropriate levels of supervision, we agree with commenters that there should be a mechanism for independent consideration of the most appropriate supervision level for individual therapeutic services to ensure that CMS purchases safe, quality outpatient care. Accordingly, while we are maintaining our policy that, in general, direct supervision is required for all outpatient therapeutic services, we will establish a process that provides for independent evaluation of the appropriate level of supervision for specific therapeutic services. We note that in considering the appropriate level of supervision for individual services, we may find that a higher level of supervision, (personal supervision) is appropriate for certain services, as well as finding that general supervision is appropriate for some services.

Therefore, in the CY 2012 OPPS rulemaking cycle, we will propose to establish an independent review process that will allow for an assessment of the appropriate supervision levels for individual hospital outpatient therapeutic services. At this point, we believe this process should include a committee with representation of many types of providers including rural providers, and that it should include a time frame for submitting requests for the assessment of individual services and considering potential changes, criteria for evaluating each service, and a means for documenting recommended supervision levels. We are considering the possibility of using CMS' Federal Advisory Panel on Ambulatory Classification Groups (the APC Panel) as the independent technical committee that would review requests for consideration of supervision levels other than direct for individual services and make recommendations to CMS regarding the appropriate levels. (*http://www.cms.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp*). As described previously in this final rule with comment period, the APC Panel is chartered by statute and consists of up to 15 members, selected by the HHS Secretary or CMS Administrator, who are full-time employees of hospitals and other Medicare providers paid under the OPPS. The Panel members are

representative of various geographic areas (rural and urban) and hospital professions (administration and clinical). We request comments regarding other potential entities that may serve as a technical panel to consider supervision levels for individual services. We also request comments on how this independent review process for an alternative level of supervision might work, and on potential criteria for evaluating a service for the appropriate level of supervision.

Because we believe that it would be best to develop such a process through notice and comment rulemaking, for CY 2011, we are extending our decision not to enforce the requirement for direct supervision of therapeutic services provided to CAH outpatients. As we stated in our proposed rule (75 FR 46309), we remain concerned about establishing policies that apply only to CAHs, because that small and rural PPS hospitals experience similar resource constraints. Therefore, for CY 2011 we are expanding the scope of our decision not to enforce the requirement for direct supervision of therapeutic services to include small rural hospitals having 100 or fewer beds. For purposes of this provision, we are using the same definition of small rural hospitals as Congress recognizes for Transitional Outpatient Payments (TOPs) under section 1833(t)(7) of the Act. Our decision not to enforce the requirement for direct supervision of therapeutic outpatient services applies to rural hospitals with 100 or fewer beds for CY 2011. As we do for TOPs, we will consider hospitals to be rural if they are either geographically located in a rural area or are paid through the OPPS with a wage index for a rural area (section 70, Chapter 4, of the Medicare Claims Processing Manual (Pub. 100–04)).

Comment: Several commenters stated that the requirement for the supervisory practitioner to have hospital privileges and State licensure to perform the services they are supervising translates into requiring licensure in the same specialty as those services. One hospital expressed concern about the language regarding "hospital privileges," stating that it forced hospitals to modify their bylaws and privileging documents to assure that a large majority of their medical staff could supervise. They stated that, in the past, supervision was carried out based on "scope of practice" and that CMS' new language regarding privileges presents new requirements.

Response: We do not believe that we have made substantive changes to the requirements regarding the supervisory practitioner's ability to perform services that he or she is supervising since we issued the first supervision rules in CY 2000. In the CY 2000 regulation text requiring direct supervision for therapeutic outpatient services in a PBD, we required that the supervisory physician be immediately available to furnish assistance and direction throughout the performance of the procedure. In order to furnish assistance and direction, we believe that a physician would have to be State licensed and possess hospital privileges to perform that procedure. As the commenter noted, in our CY 2010 OPPS/ASC final rule with comment period, we elaborated on this requirement when we stated that the supervisory practitioner "must have, within his or her State scope of practice and hospital-granted privileges, the ability to perform the service or procedure" that he or she is supervising (74 FR 60580).

However, we also have stated since 2000 that, in many circumstances, we believe that the supervising physician can furnish assistance and direction within their State scope of practice and hospital granted privileges without being of the same specialty as the service that is being performed (65 FR 18525). For example, we believe that blood transfusions do not require supervision by a hematologist and that an internist would typically possess hospital privileges and State licensure to provide and to supervise blood transfusion services. On the other hand, we have been clear that we require the supervisory practitioner to be knowledgeable enough about the service to be able to furnish assistance and direction, and not merely manage an emergency. Therefore, not all practitioners are qualified to supervise services of any specialty. Nonetheless, for many common OPPS services, we believe that hospitals can adjust their bylaws and privileging standards sufficiently to cover practitioners whom they wish to act in a supervisory capacity.

Comment: Commenters requested that CMS redefine direct supervision to broaden the definition of "immediate availability" and to allow the supervisory practitioner to be located in areas that are in close proximity to the hospital or PBD, but not on the hospital campus (or nonhospital space on the hospital campus) or in the PBD. With regard to "immediate availability," some commenters stated that, in many cases, the requirement to be immediately available (which we have described as physically present, interruptible, and able to furnish assistance and direction throughout the performance of the service) negates any benefit of allowing the supervisory practitioner to be present anywhere on campus. As discussed above, the commenters noted that the requirement to be "immediately available" in CMS' current definition of direct supervision in the hospital actually determines how far away the supervisory practitioner can be located because he or she must use their discretion to decide where they can be physically located within the hospital campus, given other activities they may be involved in and the amount of time it would take to reach the hospital nursing and auxiliary staff that he or she is supervising. Commenters stated that, practically speaking, emergency room physicians or nonphysician practitioners cannot supervise because they would not be interruptible if they were engaged in any other activity. With regard to being on the hospital campus or in the PBD, commenters indicated that there are many locations that would allow a physician to be immediately available that are not on the hospital campus or in the PBD. Specifically, commenters provided personal situations where a physician office or clinic is located in buildings adjacent to a PBD or hospital campus. Commenters noted that many of these locations are closer to the site of service than are parts of the hospital campus. In a similar case, a practitioner may perform services in two adjacent clinics within a single building, but one clinic is provider based and the other is not. We have received requests during the normal course of the year as well in public comments to our proposed rule requesting that we allow supervision from both locations.

Commenters also indicated that many CAHs and small or rural PPS hospitals have particular difficulty staffing a hospital in the situation where a primary care physician directly refers a patient after normal business hours for chemotherapy, drug administration, hydration, observation or other services from their office or from on-call in a location that is very close to the hospital campus but not on the campus. In general, these commenters believed that requiring any physician or nonphysician practitioner to be available is excessively burdensome and difficult to staff if there is no other activity to occupy the physician in the hospital. In addition, several commenters requested that CMS redefine direct supervision or immediate availability to allow for availability in ways other than appearing in person, and asked that CMS consider availability using technological advances in telemedicine

and other remote mechanisms. Commenters also requested that CMS consider redefining direct supervision to allow the supervising physician to be in close proximity to the department or hospital.

Response: Having carefully considered the comments regarding the challenges to providing direct supervision created by our requirement that the physician or nonphysician practitioner be either "in the hospital or CAH" or "in the provider based department," we are revising our definition of direct supervision for hospital outpatient therapeutic services in § 410.27(a)(1)(iv)(A) and (B) to remove the reference to "on the same campus" or "in the off-campus provider-based department of the hospital" and we are removing our definition of "in the hospital or CAH" provided under § 410.27(g) entirely. The definition of direct supervision will be revised simply to require immediate availability, meaning physically present, interruptible, and able to furnish assistance and direction throughout the performance of the procedure but without reference to any particular physical boundary. Since the new definition will now apply equally in the hospital or in on-campus or off-campus PBDs, we are removing paragraphs (a)(1)(iv)(A) and (B) of § 410.27 altogether. The new definition of direct supervision under § 410.27(a)(1)(iv) will now state, "For services furnished in the hospital or CAH or in an outpatient department of the hospital or CAH, both on- and off-campus, as defined in section 413.65 of this subchapter, 'direct supervision' means that the physician or nonphysician practitioner must be immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or nonphysician practitioner must be present in the room when the procedure is performed. For pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services, direct supervision must be furnished by a doctor or medicine or osteopathy as specified in §§ 410.47 and 410.49, respectively." This new definition of direct supervision will apply to hospitals and CAHs equally beginning in CY 2011. However, as already discussed, we are extending our notice of nonenforcement to CAHs and small rural hospitals with 100 or fewer beds through CY 2011. For purposes of this provision, we are using the same definition of small rural hospitals as Congress recognizes for TOPs under section 1833(t)(7) of the Act. Our decision not to enforce the requirement for direct supervision of therapeutic outpatient services applies to rural hospitals with 100 or fewer beds for CY 2011. As we do for TOPs, we will consider hospitals to be rural if they are either geographically located in a rural area or are paid through the OPPS with a wage index for a rural area (Section 70, Chapter 4, of the Medicare Claims Processing Manual (Pub. No. 100–04)).

This extension will allow CAHs and small rural hospitals to prepare to meet this definition of direct supervision in CY 2012.

Our goal in implementing this policy is twofold. First, we wish to allow for flexibility in providing for direct supervision from a location other than the hospital campus or PBD that still allows the physician to be immediately available to furnish direction and assistance. We wish to give CAHs and other hospitals more flexibility to meet the direct supervision requirement by allowing physicians or other practitioners in locations that are close to the hospital but not in actual hospital space to directly supervise services that are within their State scope of practice and hospital granted privileges, so long as these individuals remain immediately available. This policy also allows supervision from any location within a building off-campus that houses multiple PBDs of a hospital as long as the supervising practitioner is immediately available, rather than requiring a supervising practitioner to be located within each PBD in that building.

We note, however, that we are not relaxing the requirement that, for direct supervision, the supervisory physician or nonphysician practitioner must be immediately available, meaning that the supervisory practitioner must be physically present and interruptible. We wish to emphasize that once we remove reference to "in the hospital" or "in the provider based department," we continue to expect the supervisory practitioner to be physically present for the services he or she is supervising. As in the past, we are not defining immediate availability in terms of time or distance. We believe that removing specific boundaries provides reasonable flexibility but also holds the practitioner accountable for determining, in individual circumstances, how to be physically and immediately available when supervising services provided "incident to" a physician's service in the outpatient setting.

Although commenters again requested this year that we revise our definition of immediately available to recognize availability by telephone or modes other than in person, we believe that the requirement for physical presence distinguishes direct supervision from general supervision. Granting these requests would amount to revising the definition of direct supervision to be, for all intents and purposes, general supervision. Section 410.32(b)(3)(i) of the regulations defines general supervision to mean that "the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure." Rather than further modify the definition of direct supervision to accommodate more flexibility in the definition of immediately available, as discussed above, we intend to establish an independent review process to assess the appropriate supervision levels for specific services. We are retaining all other current requirements for direct supervision such as clinical appropriateness of the supervisor and an ability to step in and perform as we discuss in Section 20.5.2, Chapter 6, of the Medicare Benefit Policy Manual (Pub. No. 100–02).

With respect to telecommunication, we note that direct supervision requires the ability to be physically present immediately, and to be able to furnish assistance and direction throughout the performance of the procedure (74 FR 60580). We do not see how a practitioner who is only remotely available by phone or other means of telecommunication could fulfill these requirements and, therefore, we do not consider availability by means of telecommunication to be an acceptable means of providing direct supervision. However, this issue might potentially be considered by the independent panel in future years.

Comment: Several commenters asked CMS to continue to allow nurse practitioners and physician assistants to perform hospital outpatient therapeutic services under general supervision.

Response: As we have delineated in prior rules (74 FR 60590 through 60591) and manual guidance (Medicare Benefit Policy Manual (Pub. No. 100–02), Chapter 6, Section 20.5.2), beginning January 1, 2010, in accordance with 42 CFR 410.27(a)(1)(iv), in addition to physicians and clinical psychologists, licensed clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists, and a certified nurse-midwife may directly supervise therapeutic services that they may personally furnish in accordance with State law and all additional requirements, including those specified at 42 CFR 410.71, 410.73, 410.74, 410.75, 410.76, and 410.77. These

nonphysician practitioners are specified at 42 CFR 410.27(f). Under our current policy, a physician assistant may perform hospital outpatient therapeutic services under general supervision because, in accordance with § 410.74, a physician assistant must perform outpatient therapeutic services under general supervision. Similarly, nurse practitioners can perform hospital outpatient therapeutic services so long as they furnish them "in collaboration with" a physician in accordance with § 410.75. The rules for provision of diagnostic services by nurse practitioners and physician assistants are delineated in Section 20.4.4 of the Medicare Benefit Policy Manual and we summarize them below in our discussion of supervision of outpatient diagnostic services.

Comment: Commenters made many of the same requests that were made during the previous rulemaking period, specifically that CMS allow PR, CR, and ICR services to be supervised by nonphysician practitioners. Commenters also requested that CMS change the required level of supervision for these services from direct to general supervision. One commenter stated that services provided "off-site," should not require direct supervision because the staff is specially trained and the patients are medically strong enough to participate in the treatments. Another commenter expressed appreciation for the clarification in the proposed rule that the outpatient departments of CAHs are a covered setting for the provision of PR, CR, and ICR services. However, the commenter asserted that the outpatient departments of hospitals, including CAHs, are deemed to have met the direct supervision requirement by the "presumption" language in section 144(a)(2)(B) of Public Law 110–275 (MIPPA) and that consequently these facilities are not required to provide direct supervision.

Response: As we stated in the CY 2010 OPPS/ASC final rule with comment period, we do not believe that the statute provides the flexibility for us to permit anyone other than a physician to supervise hospital outpatient PR, CR, and ICR services because nonphysician practitioners are not physicians as defined in section 1861(r)(1) of the Act. The statutory language of sections 1861(eee)(2)(B) and (eee)(4)(A) and section 1861(fff)(1) of the Act (as added by section 144(a)(1) of Pub. L. 110–275) defines PR, CR, and ICR programs as "physician-supervised." More specifically, section 1861(eee)(2)(B) of the Act establishes that, for PR, CR and ICR programs, "a physician is immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program, except that, in the case of items and service furnished under such a program in a hospital, such availability shall be presumed.* * *" The text of the statute uses the word "physician" and does not include nonphysician practitioners. Also, as we explained in the CY 2009 OPPS/ASC proposed rule and final rule with comment period (73 FR 41518 through 41519 and 73 FR 68702 through 68704, referencing the April 7, 2000 OPPS final rule (65 FR 18525)), the "presumption" or "assumption" that a physician is available to provide direct supervision means that direct physician supervision is the standard. We have assumed this requirement is met on hospital premises (meaning we have expected that hospitals are meeting this requirement) because staff physicians would always be nearby in the hospital. In other words, the requirement is not negated by a presumption that the requirement is being met. Hence, while we have some flexibility to determine the type of practitioner who may supervise other hospital outpatient therapeutic services, in the case of PR, CR, and ICR services specifically, the statutory language does not provide such flexibility. Instead, the statute imposes strict requirements, describing the direct physician supervision standard for PR, CR, and ICR services, and gives us no flexibility to modify the requirement to allow for other supervisory practitioners or another level of supervision. Nevertheless, we refer the commenters to our revised definition of direct supervision, which requires only the supervisory practitioner's immediate availability rather than any particular geographic location in § 410.27(a)(1)(iv) for CY 2011, and note that this new definition applies to the direct physician supervision of PR, CR, and ICR services.

Comment: Several commenters asserted that registered nurses (RNs) are board-certified or otherwise qualified to provide all necessary supervision of the extended duration services CMS proposed and of other services, for example, observation, IV hydration, chemotherapy, blood transfusions and patient-controlled anesthesia pumps. Commenters provided many examples of nurses handling initial reactions to blood transfusions, chemotherapy and other services by redirecting the service according to protocol or specialized knowledge of the service (for example, changing rate of infusion), or by referring emergencies to medical response or "code" teams. One commenter stated that CMS should add clinical experience as a qualification under "clinical appropriateness" for direct supervision; the commenter asserted that nurses are more qualified than physicians to supervise certain procedures because they have more experience in performing them.

Response: We support all specific training nurses may receive to administer safe and quality specialized services, such as chemotherapy, under direct supervision. However, we believe there is an important distinction between ability and training to administer a service, and ability to supervise a service or to administer it without supervision. The Act specifically recognizes certain professionals (nonphysician practitioners) to furnish certain services that would be considered physicians' services if furnished by a physician, and we have recognized that it is appropriate to permit these individuals to supervise or to perform the services themselves. In general, nurses are not afforded this authority. For example, we received a comment referencing safety standards for chemotherapy administration which supported specialized training of nurses, mid-level practitioners or physicians to administer chemotherapy, but these standards also recommended that either a mid-level practitioner or a physician be on site at all times to supervise the administration of those services. We emphasize that Medicare's supervision rules do not govern who may perform a service. Rather, they govern who must be available to furnish assistance and direction through the procedure should developments require a change in the course of treatment in order to ensure a therapeutic outcome. For these reasons, we do not believe that RNs should be permitted to provide all necessary supervision of outpatient therapeutic services.

We are concerned with the number of comments we received suggesting that protocols, processes, and procedures may substitute for evaluation by a physician or nonphysician practitioner and orders for treatment. As previously stated in this discussion, § 410.27(a)(1)(ii) of the regulations states that Medicare Part B pays for hospital services and supplies furnished incident to a physician's service to outpatients if they are provided "as an integral though incidental part of physician's services." In addition, we have stated in section 20.5.1, Chapter 6 of the Medicare Benefit Policy Manual that "during any course of treatment rendered by auxiliary personnel, the physician must

personally see the patient periodically and sufficiently often enough to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen." Well-developed protocols, processes, and procedures can assist nurses in their management of a particular patient, allowing them to assess the patient's reaction to a course of treatment. We believe that quality and thoughtful nursing staff are a key component in the delivery of safe and quality care. However, protocols cannot address every possible development during a course of treatment. We believe that a physician or nonphysician practitioner who has had specific training and met further licensure and qualification requirements permitting a broader scope of practice must be available to evaluate the patient, provide assistance and direction, and order additional services if needed. Protocols cannot address all circumstances, nor can they substitute for the training and authority to redirect the service or potentially order a different course of treatment.

Comment: Many commenters continued to express the opinion that supervision requirements in CAHs should be limited to the requirements of their CoPs and that CAHs should be able to maintain a general supervision standard for the provision of all hospital outpatient therapeutic services. They asserted that CMS is promulgating two conflicting rules in that the supervision requirements for payment conflict with the supervision requirements delineated in the CAH CoPs. They asserted that Medicare is "forcing CAHs to provide life-saving services" for which they will not be reimbursed since they are not able to provide direct supervision. Another commenter asked if Advanced Beneficiary Notices (ABNs) could be distributed to patients who present to the hospital for services requiring direct supervision when such supervision is not available. On the other hand, several commenters recommended that CMS require CAHs to operate under the same supervision rules as all other types of hospitals. One commender recommended that supervision levels should only vary by type of service and safety requirements. One commenter, MedPAC, supported our recommendation to treat CAHs and small rural hospitals equally, and suggested that we better align the CAH CoPs with final payment requirements to better clarify supervision requirements for hospitals.

Response: As we discussed above, we disagree that our payment regulations requiring direct supervision for payment of outpatient services conflict with CAH CoPs. The CoPs and payment rules are written for different purposes. As we stated in our proposed rule (75 FR 46304), in order to participate in Medicare, CAHs must, at a minimum, follow their CoPs which ensure a basic environment of safety in the hospital. Under their CoPs, CAHs are permitted but not required to provide a broad array of hospital outpatient services. However, in order to bill and be paid for outpatient services, CAHs must meet additional payment requirements for specific services, including supervision requirements or, for example, the requirement for timed notes in the medical record for observation services. We have previously indicated why we believe supervision is an important requirement to ensure that Medicare purchase safe, quality outpatient care. We continue to believe that supervision is an important payment requirement for CAHs as well as other hospitals, and that Medicare should ensure the program is purchasing a minimum level of safe, quality care, wherever that care is provided. We have stated that unlike inpatients, outpatients do not have a plan of care, that a treating physician in the community may not be aware that outpatient services are being delivered, and that hospitals do not necessarily have an established relationship with registered outpatients the way they do for admitted inpatients (74 FR 60582).

We continue to disagree with commenters that we need to somehow "reconcile" the payment regulations for outpatient therapeutic services with CAH CoPs establishing minimum institutional safety and quality requirements for the services that CAHs provide. However, while we expect to retain a default requirement of direct supervision for outpatient therapeutic services, we believe that the issue of perceived discrepancy may be resolved as we move forward with our plan to establish a process that will lead to the assessment and adoption of an appropriate level of supervision for individual services. Specifically, as we begin to consider and adopt different levels of supervision for individual services, the distinction between the CAH CoPs and payment regulations should become more evident. We believe that recognizing a modified supervision approach for the extended duration services for CY 2011, discussed in more detail below, is a step towards clarifying the distinction between the payment rules that are applicable for specific services from the CoPs that apply to the facility in general.

As described in our manual provisions (Medicare Claims Processing Manual (IOM 100–04), Chapter 30, Sections 50.2.1 and 50.5), providers may only issue ABNs when Medicare will deny an otherwise covered item or service either as not reasonable and necessary under section 1862(a)(1) of the Act or because the item or service constitutes custodial care under section 1862(a)(9) of the Act. If Medicare withheld payment for a hospital outpatient service due to lack of direct supervision as required in our rules and regulations, the payment denial would not be for lack of medical necessity or because the item or service constituted custodial care. Therefore, failure to provide direct supervision is not a valid reason to issue a beneficiary an ABN, and hospitals are not permitted to do so.

Comment: Many commenters appreciated our proposal for extended duration services as an attempt to offer flexibility to CAHs and small rural hospitals to meet supervision requirements when providing these services. Many commenters favored the proposal overall, but offered several recommended refinements or revisions. First, commenters expressed concern that the requirement for direct supervision during the initiation of an extended duration service would compromise patient safety in small rural hospitals and CAHs because auxiliary staff would have to wait for the supervisory practitioner to arrive before initiating critical treatment. They recommended that CMS allow these services to be provided under general supervision for the duration of the service.

Many commenters did not believe that the list was long enough and suggested that we add additional services, although many of these services did not meet the stated criteria to be considered a nonsurgical extended duration service. We note that we addressed other services requested for general supervision in our first comment and response in this section. Many commenters requested general supervision of chemotherapy administration and blood transfusion. Several commenters also believed that certain portions of the post-operative recovery period did not need direct supervision and that after a certain amount of time has passed, patients are typically stable enough to be monitored by auxiliary personnel. They requested that CMS allow general supervision for portions of the post-operative period or designate the post-operative period as an extended duration service.

Several commenters agreed that CMS should not further define "initiation" or "stable." They noted that these are new unfamiliar terms in the context of extended duration services and were

concerned about liability. Commenters believed that they might be subject to inspection and interpretation of their decision about the transition of care by individuals who were not qualified to make a medical judgment about the need for a practitioner, and that they would be penalized for failures to adequately document the transition. The commenters stated that the determination that a patient is stable enough to transition to general supervision may create personal liability. They indicated that it may be difficult to properly judge or navigate the terms "initiation" and "stable" because they will vary with different circumstances, for example the practitioner who transfers the patient to a reduced level of supervision care may not be the same practitioner who initiated care.

Finally, commenters expressed their views as to whether the point of transition from direct supervision to general supervision should be documented in the medical record or identified in a hospital protocol, and on how CMS might review the supervisory practitioner's decision to move from direct to general supervision to monitor for proper billing should an adverse event occur. Several commenters favored documenting the transition to general supervision in the medical record or in progress notes, and one commenter specified that a physician order should be used. One commenter suggested a system that would grade the level of clinical decision making, similar to an existing system that grades level of risk and patient stability with parameters such as "Abrupt Change in Neurologic Status." However, many other commenters expressed reservations about documentation, concerned that documenting the point of transfer will provide ample opportunity for practitioner audit and liability since carrying out the transition is an unfamiliar arena involving clinical judgment and newly defined or undefined terms. Some commenters expressed concern about increasing providers' paperwork and administrative burden.

Response: We appreciate commenters support for our proposal to require, for certain extended duration services, direct supervision at the initiation of the service followed by general supervision for the remainder of a service at the discretion of the supervising physician or nonphysician practitioner once that physician has determined that the patient is stable.

We do not believe that requiring direct supervision for the initiation of the service for extended duration services will compromise patient safety in CAHs and small rural hospitals when they provide these services. We believe that many of the extended duration services frequently are referred services, giving the hospital or CAH time to arrange for a supervisory physician or nonphysician practitioner to be available. Specifically with regard to observation services, we noted in Section 290.5.1 of Chapter 4 of the Medicare Claims Processing Manual (Pub. No. 100–04) that "(a) the beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician," and "(b) the medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation services." Because we require an evaluation of patient risk at the beginning of observation services, except in cases of direct referral we did not believe that the physician would not be available during the initiation of the service.

We also believe that hospitals typically would not need to stop delivery of extended duration services to a patient because a supervisory physician or nonphysician practitioner is not yet available. We note that the hospital frequently conducts diagnostic tests for patients presenting to the emergency department, many of which require a general level of supervision, which can allow time for a supervising physician or nonphysician practitioner to become available for the initiation of therapeutic services. Thus, in those circumstances where the patient presents to the emergency department and requires an extended duration service, we believe that the supervising physician or nonphysician practitioner could be immediately available for most, if not all, of the initiation period. We further note that we have removed the physical boundary requirement in the definition of direct supervision in order to allow for the supervising practitioner greater flexibility in location while still meeting the requirement to be immediately available.

We do not believe it would be appropriate without further assessment to define chemotherapy, blood transfusion, and the recovery period for surgical services as nonsurgical, extended duration therapeutic services. After a preliminary review of literature on chemotherapy administration, we believe that service-specific assessment may be necessary to determine the level of supervision that is safe. Adverse events can be severe, even fatal, and they seem to vary by type of chemotherapy being administered as well as the mechanism of administration. We also note that recent safety standards seem to support the equivalent of direct supervision of chemotherapy (*http://www.asco.org/ASCOv2/Practice+%26+Guidelines/Quality+Care/Quality+Measurement+%26+Improvement/ASCO-ONS+Standards+for+Safe+Chemotherapy+Administration*). We remain equally concerned about the safety of blood transfusion should circumstances require a physician to assess the situation and order a change in the course of treatment. We also do not believe it would be appropriate, without further assessment, to require general supervision for the recovery period for surgical services. We excluded all surgical services including recovery time from our proposal regarding extended duration services because we believe the surgeon should evaluate his or her patient during the recovery period. We believe that the best course of action is to exclude these services from our list of nonsurgical extended duration services and to include them in the list of services to be evaluated early on through the independent review process for service-specific supervision levels that we will establish for CY 2012.

We thank commenters who agreed with our proposal not to define the term "stable" and not to further define the term "initiation," and as we proposed, we will not further define these terms. Thus, the finalized definition of "initiation" in § 410.27(a)(1)(v)(B) is "the beginning portion of a service ending when the patient is stable and the supervising physician or appropriate nonphysician practitioner believes the remainder of the service can be delivered safely under general supervision."

With regard to documentation of transition from direct to general supervision, we are sympathetic to commenter concerns regarding potential liability and administrative burden. However, we also believe that in order to assure adequate patient safety and communication among hospital staff, the point of transition to general supervision should be documented prominently in progress notes or in the medical record. Therefore, we are finalizing our requirement that the transition from direct to general supervision be documented in the progress notes or in the medical record,

but we are otherwise leaving the manner of documentation to the discretion of each supervising practitioner.

After review of the public comments, we are finalizing our proposed nonsurgical extended duration services described in new § 410.27(a)(1)(v).

Comment: During the past year, we were often questioned about clinical requirements for practitioners supervising extremely specialized services, notably radiation oncology services. One commenter requested that CMS consider the direct supervision requirement to be met for diagnostic or therapeutic radiation oncology services if a non-specialist practitioner who can handle an emergency provides the direct supervision and also has access by phone or other telemedicine link to a specialist who is able to change the plan of care should the need arise. One commenter asserted that one does not have to posses the clinical skills to fully provide a service in order to be an effective supervisor.

Response: As we have stated in the Medicare Benefit Policy Manual (Pub. No. 100–02), Chapter 6, Section 20.5.24, "the supervisory physician or nonphysician practitioner must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure. Specially trained ancillary staff and technicians are the primary operators of some specialized diagnostic or therapeutic equipment, and while in such cases CMS does not expect the supervisory practitioner to operate this equipment instead of a technician, CMS does expect the physician or nonphysician practitioner that supervises the provision of the service must be knowledgeable about the test and clinically appropriate to furnish the test. The supervisory responsibility is more than the capacity to respond to an emergency, and includes furnishing assistance and direction throughout the performance of a procedure and, as appropriate to the supervisory physician or nonphysician practitioner and the patient, to change a procedure or the course of care for a particular patient. CMS would not expect that the supervisory practitioner would make all decisions unilaterally without informing or consulting the patient's treating physician or nonphysician practitioner." We do not believe it is sufficient or consistent with our rules for direct supervision for the individual on site to be capable of only emergency management. The supervisory practitioner or nonphysician practitioner who is physically present should have the training and knowledge to clinically redirect the service or provide additional orders.

Comment: Commenters remain concerned about the potential for liability for services provided prior to CY 2009. They requested that CMS prohibit enforcement of the direct supervision requirements applied to services furnished since January 1, 2001. They also commented that CMS' statement regarding enforcement in the CY 2010 final rule with comment period (74 FR 60587) forces hospitals to assert and provide supporting evidence that any divergence from CMS' rules during that time period was a result of error or mistake.

Response: In the CY 2010 OPPS/ASC final rule with comment period, we stated that in the case of services furnished in 2000 through 2008, "we plan to exercise our discretion and decline to enforce in situations involving claims where the hospital's noncompliance with the direct physician supervision policy resulted from error or mistake." (74 FR 60587)

In summary, after consideration of the public comments we received, we are maintaining our general requirement for direct supervision of all outpatient therapeutic services. However, we are redefining our definition of direct supervision in § 410.27(a)(1)(iv) to remove all references to physical boundaries and require only "immediate availability." We are removing § 407.27(g), which defines "in the hospital", because it is no longer necessary. In addition, through CY 2011 we will develop an independent review process for annual consideration of requests for alternative service-specific supervision levels, supported by an independent technical committee, potentially the APC Panel. We are specifically seeking comment on what the process should look like and the criteria that should be considered for identifying services for which personal, direct, or general supervision is appropriate. We will establish this process in the coming year through the CY 2012 rulemaking cycle, selecting a specific independent entity to assist in the process and establishing criteria for determining that a given service should be furnished under general or personal supervision rather than direct supervision. At least until the independent entity is in place (likely through CY 2011), we are establishing a new category of "nonsurgical extended duration therapeutic services" that require direct supervision as defined in § 410.27(a)(1)(iv) during an initiation period, followed by a minimum standard of general supervision as defined in § 410.32(b)(3)(i) for the duration of the service. The extended duration services will include the limited set of procedures identified in Table 48A of this final rule with comment period. We are adding a new paragraph (a)(1)(v) to § 410.27 to reflect this policy. In new § 410.27(a)(1)(v)(A), we are defining "nonsurgical extended duration therapeutic services" as services that can last a significant period of time, have a substantial monitoring component that is typically performed by auxiliary personnel, have a low risk of requiring the physician's or appropriate nonphysician practitioner's immediate availability after the initiation of the service, and are not primarily surgical in nature. In new § 410.27(a)(1)(v)(B), we are finalizing our definition of "initiation of the service" as the beginning portion of a service ending when the patient is stable and the supervising physician or appropriate nonphysician practitioner believes the remainder of the service can be delivered safely under his or her general direction and control without needing his or her immediate availability. We believe that these policies will address commenters' concerns while maintaining an adequate level of safety and quality of care in the hospital outpatient services that Medicare purchases.

As another interim measure, we are extending the nonenforcement policy for direct supervision of therapeutic services provided in CAHs for another year, through CY 2011, and we are expanding it during this year to include small and rural hospitals that have 100 or fewer beds. For purposes of this provision, we are using the same definition of small rural hospitals as Congress recognizes for TOPs under section 1833(t)(7) of the Act. Our decision not to enforce the requirement for direct supervision of therapeutic outpatient services applies to CAHs and rural hospitals with 100 or fewer beds for CY 2011. As we do for TOPs, we will consider hospitals to be rural if they are either geographically located in a rural area or are paid through the OPPS with a wage index for a rural area (Section 70, Chapter 4, of the Medicare Claims Processing Manual (Pub. No. 100–04)). We believe this nonenforcement policy will permit the CAHs and small and rural hospitals that do not consistently meet our direct supervision standard for outpatient therapeutic services to make appropriate adjustments over the coming year.

Finally, in our proposal, we noted that in the CY 2010 OPPS/ASC final rule with comment period, in presenting the regulation text changes for § 410.27, paragraph (a)(2) (relating to PHP

services) was inadvertently deleted from the Code of Federal Regulations. We did not receive any comments on this proposal. We are finalizing our proposal to restore paragraph (a)(2) as it originally appeared in the regulations.

TABLE 48A—LIST OF NONSURGICAL EXTENDED DURATION THERAPEUTIC SERVICES

HCPCS Code	Long description
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump.
G0378	Hospital observation service, per hour.
G0379	Direct admission of patient for hospital observation care.
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour.
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure).
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour.
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure).
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure).
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure).
96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s).
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure).
96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure).
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure).
96376	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure).

In the CY 2010 OPPS/ASC final rule with comment period, we requested comments on the issue of standardizing the levels of supervision required for partial hospitalization services (PHP) provided in CMHCs and in hospital outpatient departments. To date, we require direct supervision for PHP services provided to hospital outpatients as for all outpatient therapeutic services, and we require only general supervision for PHP services provided at CMHCs. We appreciate the comments we received in response to the final rule with comment period and are taking them into consideration. In the CY 2010 OPPS/ASC final rule with comment period, we also requested comments on supervision requirements for payment to ASCs. We have no payment-related supervision requirement for ASCs. We appreciate the comments we received in response to the final rule with comment period and are taking them into consideration.

4. Supervision of Hospital Outpatient Diagnostic Services

We have received limited correspondence and questions on our policy finalized in the CY 2010 OPPS/ASC final rule with comment period to adopt for outpatient diagnostic services furnished in hospitals and in non-hospital locations the physician supervision levels in § 410.32(b)(3) established under the MPFS and indicated on the Practice Expense Relative Value Unit file. We also applied a new definition of direct supervision in new § 410.28(e)(1) and (e)(2). As discussed above, the CY 2010 policy applies to hospitals and not to CAHs. As we discuss above, nonphysician practitioners previously performing diagnostic tests without physician supervision, within their State scope of practice and hospital-granted privileges, can continue to perform those tests without physician supervision. The CY 2010 policy now requires physician supervision of those services, unless the nonphysician practitioner is specifically exempted under § 410.32(b)(2) or there is some other provision addressing supervision for that type of nonphysician practitioner.

In this final rule with comment period, in the interest of clarity we are adopting the same change in definition of direct supervision and immediate availability for outpatient diagnostic services as we are adopting for outpatient therapeutic services, except for diagnostic services performed under arrangement in non-hospital locations under § 410.28(e)(3). For diagnostic services furnished under arrangement in non-hospital locations, direct supervision will continue to mean physical presence in the office suite as defined in § 410.32(b)(3)(ii) ("in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure"). For all other outpatient diagnostic services, direct supervision will now mean immediately available, without reference to any physical boundary. To this end, we are amending the definition of direct supervision in §§ 410.28(e)(1) and (2).

B. Payment for Preventive Services

1. Definition of "Preventive Services"

Section 4104(a) of the Affordable Care Act revised section 1861(ddd) of the Act by adding a new paragraph (3), which defines the term "preventive services." Preventive services are defined as:

- Screening and preventive services currently described in section 1861(ww)(2) of the Act, except for electrocardiograms described in section 1861(ww)(2)(M) of the Act;
- An initial preventive physical examination (IPPE) as defined in section 1861(ww) of the Act; and
- Personalized prevention plan services (PPPS), also known as the "Annual Wellness Visit" (AWV), as defined in section 1861(hhh) of the Act (which was added by section 4103 of the Affordable Care Act).

The services specified in the definition of "preventive services" at section 1861(ddd)(3)(A) of the Act, as

cross-referenced to section 1861(ww)(2) of the Act, excluding electrocardiograms, include the following:

- Pneumococcal, influenza, and hepatitis B vaccine and administration;
- Screening mammography;
- Screening pap smear and screening pelvic examination;
- Prostate cancer screening tests;
- Colorectal cancer screening tests;
- Diabetes outpatient self-management training (DSMT);
- Bone mass measurement;
- Screening for glaucoma;
- Medical nutrition therapy (MNT) services;
- Cardiovascular screening blood tests;
- Diabetes screening tests;
- Ultrasound screening for abdominal aortic aneurysm (AAA); and
- Additional preventive services identified for coverage through the national coverage determination (NCD) process.

We note that, at the time of issuance of the CY 2011 OPPS/ASC proposed rule, the only additional preventive service identified for coverage through the NCD process was HIV testing. We released a proposed national coverage determination for smoking cessation services for asymptomatic patients (CAG–00420N, "Proposed Coverage Decision Memorandum for Counseling to Prevent Tobacco Use") in May 2010 on the CMS Web site at: *http://www.cms.gov/mcd/index_list.asp?list_type=nca.* We indicated that we would address the applicability of section 4104 of the Affordable Care Act to these services if an NCD establishing them as additional preventive services was finalized before the CY 2011 OPPS/ASC final rule with comment period was issued (75 FR 46310). As of August 25, 2010, CMS finalized an NCD for "Counseling to Prevent Tobacco Use," and established coverage of smoking cessation services for asymptomatic patients, thus qualifying them as "additional preventive services" as defined at section 1861(ddd)(3)(A) of the Act, as cross-referenced to section 1861(ww)(2) of the Act.

We included our proposals to implement the coverage and payment provisions for the AWV providing PPPS in the CY 2011 MPFS proposed rule (75 FR 40128 through 40129). Therefore, individuals were instructed to submit public comments on the proposed coverage of and payment for the AWV providing PPPS under the provisions of the Affordable Care Act in response to the CY 2011 MPFS proposed rule. The implementing regulations regarding coverage of the IPPE are already established under existing 42 CFR 410.16 and remain unchanged by the Affordable Care Act. As discussed below in section XII.B.2. of this final rule with comment period, we are presenting our proposed and final policies for the application or waiver of coinsurance and the Part B deductible for preventive services as required by sections 4104(b) and (c) of the Affordable Care Act. While commenters were directed to submit public comments on the proposed coverage of and payment for the AWV providing PPPS under the provisions of the Affordable Care Act in response to the CY 2011 MPFS proposed rule, we did receive some comments on hospital payment for these services, which we address below.

2. Coinsurance and Deductible for Preventive Services

Sections 4104(b) and 10406 of the Affordable Care Act amended section 1833(a)(1) of the Act to require 100 percent payment for the IPPE and for those Medicare-covered preventive services that are recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual. This requirement waives any coinsurance or copayment that would otherwise apply under section 1833(a)(1) of the Act for the IPPE and for those items and services listed in section 1861(ww)(2) of the Act (excluding electrocardiograms) to which the USPSTF has given a grade of A or B. In addition, section 4103(c) of the Affordable Care Act waives the coinsurance or copayment for the AWV providing PPPS. The coinsurance or copayment represents the beneficiary's share of the payment to the provider or supplier for furnished services. Coinsurance generally refers to a percentage (for example, 20 percent) of the Medicare payment rate for which the beneficiary is liable and is applicable under the MPFS and ASC payment system, while copayment generally refers to an established amount that the beneficiary must pay that is not necessarily related to a particular percentage of the Medicare payment rate, and is applicable under the OPPS. We refer readers to the CY 2011 MPFS final rule with comment period for the provisions related to payment for preventive services, including waiver of the deductible and copayment, under the MPFS, and to section XV.D.1.d. of this final rule with comment period for our proposed and final policies to implement the provisions related to payment for preventive services under the ASC payment system.

Section 4104(c) of the Affordable Care Act amended section 1833(b)(1) of the Act to waive the Part B deductible for preventive services described in section 1861(ddd)(3)(A) of the Act that have a grade of A or B from the USPSTF for any indication or population and are appropriate for the individual. In addition, section 4103(c)(4) of the Affordable Care Act waives the Part B deductible for the AWV providing PPPS. These provisions are effective for services furnished on or after January 1, 2011. We note that section 101(b)(2) of the MIPPA previously amended section 1833(b) of the Act to waive the Part B deductible for the IPPE, effective January 1, 2009.

As we indicated in the CY 2011 OPPS/ASC proposed rule (75 FR 46310 through 46311), not all preventive services described in paragraph (A) of section 1861(ddd)(3) of the Act are recommended by the USPSTF with a grade of A or B, and therefore, some of the preventive services do not meet the criteria in sections 1833(a)(1) and 1833(b)(1) of the Act for the waiver of the deductible and coinsurance. However, the changes made by section 4104 of the Affordable Care Act do not affect most of the preexisting specific provisions listed in existing § 410.160(b) and § 410.152 of the regulations (which reflect the provisions found in sections 1833(a) and 1833(b) of the Act) that waive the deductible and coinsurance for specific services. For example, section 1833(a)(1)(D) of the Act waives the coinsurance and section 1833(b)(3) of the Act waives the deductible for clinical laboratory tests (including those furnished for screening purposes). Section 4104 of the Affordable Care Act does not change these provisions and the waiver of both the deductible and coinsurance remains in place for all laboratory tests, regardless of whether the particular clinical laboratory test meets the criteria of section 4104 for the waiver of the deductible and coinsurance as a preventive service.

The following preventive services listed in section 1833(ddd)(3)(A) of the Act are not recommended by the USPSTF with a grade of A or B for any indication or population: (1) Digital rectal examination provided as a prostate cancer screening service; (2) glaucoma screening; (3) diabetes outpatient self-management training; and (4) barium enema provided as a colorectal cancer screening service.

Specifically, HCPCS code G0102 (Prostate cancer screening; digital rectal exam), which does not have a grade of

A or B from the USPSTF for any indication or population, will continue to be subject to the deductible and coinsurance. However, the deductible and coinsurance for HCPCS code G0103 (Prostate cancer screening; prostate specific antigen test (PSA)) will continue to be waived under sections 1833(a)(1)(D) and 1833(b)(3) of the Act as a clinical laboratory test, even though it also does not have a grade of A or B from the USPSTF.

Glaucoma screening services, described by HCPCS codes G0117 (Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist) and G0118 (Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist), will continue to be subject to the deductible and coinsurance requirements because these services are not recommended with a grade of A or B by the USPSTF for any indication or population. Similarly, diabetes outpatient self-management training is currently not rated by the USPSTF; therefore, the deductible and coinsurance requirements will continue to apply.

Barium enemas provided as colorectal cancer screening tests, described by HCPCS codes G0106 (Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema) and G0120 (Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema) do not have a grade of A or B from the USPSTF for any indication or population. However, the deductible does not apply to barium enemas provided as colorectal cancer screening tests because colorectal cancer screening tests are explicitly excluded from the deductible under section 1833(b)(8) of the Act. However, there is no specific exclusion of barium enemas from the coinsurance requirement at section 1833(b)(1) of the Act. Therefore, this requirement, as applicable, continues to apply to barium enemas. We note that the USPSTF has given a grade of A to colonoscopy, flexible sigmoidoscopy, and fecal occult blood screening tests, and, as a result, these services qualify for the statutory waiver of both the deductible and coinsurance.

We also note that the USPSTF ceased to make recommendations with regard to vaccines and vaccine administration after CY 1996, so as not to conflict with the recommendations of the CDC's Advisory Committee on Immunization Practices. However, the USPSTF's most recent vaccine recommendations, which were never withdrawn by the USPSTF, gave a grade of B to the influenza and pneumococcal vaccines and their administration and a grade of A to the hepatitis B vaccine and its administration. While sections 1833(a)(1) and 1833(b)(1) of the Act (as amended by section 4104 of the Affordable Care Act) require that the preventive services receive a grade of A or B from the USPSTF for the coinsurance and deductible to be waived, the statute does not specify that the recommended grade must be furnished within any given timeframe. The USPSTF's grades from 1996 for these preventive services are the most current USPSTF grades and have never been withdrawn. Therefore, we believe that these preventive services meet the requirements of the statute for the waiver of the deductible and coinsurance. We also note that the CDC's Advisory Committee on Immunization Practices currently recommends influenza, pneumococcal, and hepatitis B vaccines.

Table 38 of the CY 2011 OPPS/ASC proposed rule (75 FR 46312) displayed the CPT/HCPCS codes (paid under the OPPS or at reasonable cost) that we proposed as "preventive services" under section 1861(ddd)(3)(A) of the Act. Table 38 also provided the most recent USPSTF grade, if any, that was the basis for our proposed policy with regard to the waiver of the deductible and coinsurance, as applicable. In the proposed rule, we noted that, in developing recommendations regarding preventive services, we recognize that the USPSTF may make recommendations that are specific to an indication or population, at times including characteristics such as gender and age in its recommendations. In accordance with section 4101 of the Affordable Care Act, we proposed to waive the deductible and coinsurance for any Medicare covered preventive service with no limits on the indication or population as long as the USPSTF has recommended the preventive service for at least one indication and/or population with a grade of A or B. However, we noted in the CY 2011 OPPS/ASC proposed rule (75 FR 46311) that all existing Medicare coverage policies for such services, including any limitations based on indication or population, continue to apply. In some cases, national coverage policies may currently limit Medicare coverage based on the indication or population, consistent with the USPSTF's recommendations with a grade of A or B for the indication or population. In other cases where Medicare does not explicitly noncover preventive services for a specific population or indication, we would expect that, particularly in those cases where the USPSTF recommendation grade is a D (that is, the USPSTF recommends against the service because there is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits), practitioners would only order those preventive services that are clinically appropriate for the beneficiary. We stated in the proposed rule that if we have future concerns about the appropriateness of preventive services for an indication or population in light of the USPSTF's recommendations, we may consider using our authority under section 1834(n)(1) of the Act (as added by section 4105 of the Affordable Care Act) to modify Medicare coverage of any preventive service consistent with the recommendations of the USPSTF (75 FR 46311).

We noted in the proposed rule that section 4103(c)(3)(A) of the Affordable Care Act excludes the PPPS from payment under the OPPS and establishes payment for the AWV providing PPPS when performed in a hospital outpatient department under the MPFS. In the CY 2011 OPPS/ASC proposed rule (75 FR 46311), we proposed to add a new paragraph (t) under § 419.22 of the regulations to specify that the AWV providing PPPS is excluded from payment under the OPPS. In the process of revising the regulations to reflect the exclusion of AWV providing PPPS from the OPPS, we noticed the need for existing § 419.21(e) to be updated to reflect that an IPPE may be performed within 12 months after the date of the individual's initial enrollment in Part B, effective January 1, 2009. We also noticed that existing § 419.22(m) of the regulations needed to be updated to reflect that a revised payment methodology for end-stage renal disease (ESRD) services will go into effect on January 1, 2011. Therefore, we also proposed to revise §§ 419.21(e) and 419.22(m). We referred readers to the CY 2011 MPFS proposed rule for a discussion of the proposed changes to § 410.160(b) and § 410.152 of the regulations to implement the provisions related to the definition of "preventive services" and the waiver of the coinsurance and deductible for preventive services as specified by sections 4103 and 4104 of the Affordable Care Act.

Comment: Several commenters supported CMS' proposed implementation of the Affordable Care Act provision to waive beneficiary cost-sharing for preventive services identified in section 1861(ddd)(3)(A) of the Act, and recommended by the USPSTF with a grade of A or B for any

indication or population that are appropriate for the individual, and urged CMS to finalize the proposed policy. Some commenters expressed concern that CMS' proposed implementation of the Affordable Care Act provision to waive beneficiary cost-sharing did not include an extension of the waiver of the deductible and coinsurance for vaccines recommended by CDC's Advisory Committee on Immunization Practices (ACIP) that are covered under Medicare Part D and preventive services which, while identified in section 1861(ddd)(3)(A) of the Affordable Care Act, are not designated with a grade of A or B by the USPSTF (specifically, prostate cancer screening including digital rectal examinations; glaucoma screening for high risk patients furnished by, or under direct supervision of, an optometrist or ophthalmologist; diabetes outpatient self-management training; and barium enemas provided as colorectal cancer screening tests).

Response: We appreciate the commenters' support of our proposal to waive beneficiary cost-sharing for preventive services identified in section 1861(ddd)(3)(A) of the Act, and recommended by the USPSTF with a grade of A or B for any indication or population that are appropriate for the individual. Services that are not recommended by the USPSTF with a grade of A or B do not meet the criteria in sections 1833(a)(1) and 1833(b)(1) of the Act for the waiver of the coinsurance and deductible. We also cannot waive the deductible and coinsurance for ACIP-recommended vaccines that are covered under Medicare Part D because these services do not fall under the definition of "preventive services" at section 1861(ddd)(3)(A) of the Act.

Comment: One commenter requested that CMS clarify that tobacco cessation counseling will be available to Medicare beneficiaries without application of cost-sharing or deductible requirements.

Response: As stated above, as of August 25, 2010, CMS finalized a NCD for "Counseling to Prevent Tobacco Use," and established coverage of smoking cessation services for asymptomatic patients, thus qualifying them as "additional preventive services" as defined at section 1861(ddd)(3)(A) of the Act, as cross-referenced to section 1861(ww)(2) of the Act. As reflected in Table 48B below, the deductible and coinsurance requirements will not apply to these services, effective January 1, 2011.

Comment: A few commenters requested that CMS provide clarity on the hospital billing method for the AWV providing PPPS performed in hospital outpatient facilities and requested further explanation about how hospitals may submit claims and receive payment for furnishing the AWV providing PPPS in a facility setting.

Response: Hospital outpatient facilities may bill for the first and subsequent AWVs providing PPPS, furnished to an eligible beneficiary and in a hospital outpatient facility. As noted above, section 4103(c)(3)(A) of the Affordable Care Act specifically excludes the AWV providing PPPS from payment under the OPPS and establishes payment for the AWV providing PPPS when performed in a hospital outpatient department under the MPFS. We will accept claims for payment from facilities furnishing the AWV providing PPPS in a facility setting if no physician claim for professional services has been submitted to CMS for payment. That is, we will pay either the practitioner or the facility for furnishing the AWV providing PPPS in a facility setting, and only a single payment under the MPFS will be allowed. We refer readers to section V.Q.2. of the MPFS final rule with comment period for a full discussion of the final coverage and payment provisions implemented for the AWV providing PPPS.

After consideration of the public comments we received, we are finalizing our proposal, without modification, to waive the coinsurance and Part B deductible for preventive services as specified by sections 4103 and 4104 of the Affordable Care Act. We also are finalizing our proposals to add a new paragraph (t) to § 419.22 of the regulations to specify that the AWV providing PPPS is excluded from payment under the OPPS, and to update § 419.21(e) to reflect that an IPPE may be performed within 12 months after the date of the individual's initial enrollment in Part B, effective January 1, 2009. We also are finalizing our proposals to update § 419.22(m) to reflect that a revised payment methodology for ESRD services will go into effect on January 1, 2011. We refer readers to the CY 2011 MPFS proposed rule for a discussion of the changes to § 410.160(b) and § 410.152 of the regulations to implement the provisions related to the definition of "preventive services" and the waiver of the Part B deductible and coinsurance for preventive services as specified by sections 4103 and 4104 of the Affordable Care Act.

Table 48B below displays the HCPCS codes (paid under the OPPS or at reasonable cost) that will be recognized as "preventive services" under section 1861(ddd)(3)(A) of the Act. Table 48B also provides the most recent USPSTF grade, if any, that is the basis for our final policy with regard to waiver of the Part B deductible and coinsurance, as applicable. We note that, effective January 1, 2011, CPT code 90658 is no longer payable under OPPS and has been replaced by the following HCPCS codes: Q2035 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria)); Q2036 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval)); Q2037 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin)); Q2038 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone)); and Q2039 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)).

TABLE 48B—CY 2011 DEDUCTIBLE AND COINSURANCE FOR OPPS PREVENTIVE SERVICES SPECIFIED IN SECTION 1861(DDD)(3)(A) OF THE ACT *

[includes the initial preventive physical examination (IPPE)]

Service	CY 2011 CPT/ HCPCS code	Long descriptor	USPSTF ratings [1]	CY 2010 coinsurance deductible	CY 2011 coinsurance deductible
Initial Preventive Physical Examination (IPPE).	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment.	Not Rated	Coinsurance applies and deductible is waived.	Waived.

TABLE 48B—CY 2011 DEDUCTIBLE AND COINSURANCE FOR OPPS PREVENTIVE SERVICES SPECIFIED IN SECTION 1861(DDD)(3)(A) OF THE ACT *—Continued

[includes the initial preventive physical examination (IPPE)]

Service	CY 2011 CPT/ HCPCS code	Long descriptor	USPSTF ratings [1]	CY 2010 coinsurance deductible	CY 2011 coinsurance deductible
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination.	.....	Not Waived	Not Waived.
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA).	G0389	Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening.	B	Coinsurance applies and deductible is waived.	Waived.
Screening Pap Test (Specimen Collection).	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory.	A	Coinsurance applies and deductible is waived.	Waived.
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination.	A	Coinsurance applies and deductible is waived.	Waived.
Bone Mass Measurement.	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).	B	Not Waived	Waived.
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine).	.....	Not Waived	Waived.
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).	.....	Not Waived	Waived.
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine).	.....	Not Waived	Waived.
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).	.....	Not Waived	Waived.
	77083	Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), 1 or more sites.	.....	Not Waived	Waived.
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method.	.....	Not Waived	Waived.
	G0104	Colorectal cancer screening; flexible sigmoidoscopy.	.....	Coinsurance applies and deductible is waived.	Waived.
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk.	A	Coinsurance applies and deductible is waived.	Waived.
Colorectal Cancer Screening.	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk.	.....	Coinsurance applies and deductible is waived.	Waived.
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema.	Not Rated	Coinsurance applies and deductible is waived.	Coinsurance applies and deductible is waived.
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.	.....	Coinsurance applies and deductible is waived.	Coinsurance applies and deductible is waived.
Prostate Cancer Screening.	G0102	Prostate cancer screening; digital rectal examination.	D	Not Waived	Not Waived.
Glaucoma Screening ...	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist.	I	Not Waived	Not Waived.

TABLE 48B—CY 2011 DEDUCTIBLE AND COINSURANCE FOR OPPS PREVENTIVE SERVICES SPECIFIED IN SECTION 1861(DDD)(3)(A) OF THE ACT *—Continued

[includes the initial preventive physical examination (IPPE)]

Service	CY 2011 CPT/ HCPCS code	Long descriptor	USPSTF ratings [1]	CY 2010 coinsurance deductible	CY 2011 coinsurance deductible
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist.	.....	Not Waived	Not Waived.
Influenza Virus Vaccine	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6–35 months of age, for intramuscular use.	B	Waived	Waived.
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use.	.....	Waived	Waived.
	90657	Influenza virus vaccine, split virus, when administered to children 6–35 months of age, for intramuscular use.	.....	Waived	Waived.
	Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria).	.....	N/A	Waived.
	Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval).	.....	N/A	Waived.
	Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin).	.....	N/A	Waived.
	Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone).	.....	N/A	Waived.
	Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified).	.....	N/A	Waived.
	90660	Influenza virus vaccine, live, for intranasal use.	.....	Waived	Waived.
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use.	.....	Waived	Waived.
	G0008	Administration of influenza virus vaccine.	.....	Waived	Waived.
	G9141	Influenza a (h1n1) immunization administration (includes the physician counseling the patient/ family).	.....	Waived	Waived.
	G9142	Influenza a (h1n1) vaccine, any route of administration.	.....	Waived	Waived.
	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use.	.....	Waived	Waived.
Pneumococcal Vaccine	90670	Pneumococcal vacc, 13 val im	.....	Waived	Waived.
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use.	B	Waived	Waived.
	G0009	Administration of pneumococcal vaccine.	.....	Waived	Waived.

TABLE 48B—CY 2011 DEDUCTIBLE AND COINSURANCE FOR OPPS PREVENTIVE SERVICES SPECIFIED IN SECTION 1861(DDD)(3)(A) OF THE ACT *—Continued

[includes the initial preventive physical examination (IPPE)]

Service	CY 2011 CPT/ HCPCS code	Long descriptor	USPSTF ratings [1]	CY 2010 coinsurance deductible	CY 2011 coinsurance deductible
Hepatitis B Vaccine	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use.	A	Not Waived	Waived.
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use.	.....	Not Waived	Waived.
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use.	.....	Not Waived	Waived.
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use.	.....	Not Waived	Waived.
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use.	.....	Not Waived	Waived.
Smoking and Tobacco Cessation.	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes.	A	Not Waived	Waived.
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes.	.....	Not Waived	Waived.

* This table lists only the preventive services, as defined by the Affordable Care Act, that are paid under the OPPS or at reasonable cost, and excludes preventive services such as screening mammography and cardiovascular screening blood tests that are paid under another fee schedule such as the MPFS or the Clinical Laboratory Fee Schedule. A listing of all services defined by the Affordable Care Act as preventive services can be found in this preamble and in the CY 2011 MPFS final rule with comment period. We note that any preventive service must meet the Medicare coverage guidelines for the service including being appropriate to the beneficiary to whom it is being furnished.

[1] U.S. Preventive Services Task Force Recommendations

A—The USPSTF strongly recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B—The USPSTF recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.)

C—The USPSTF makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.)

D—The USPSTF recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I—The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

3. Extension of Waiver of Part B Deductible to Services Furnished in Connection With or in Relation to a Colorectal Cancer Screening Test That Becomes Diagnostic or Therapeutic

Section 4104(c) of the Affordable Care Act amended section 1833(b) of the Act to waive the Part B deductible for colorectal cancer screening tests that become diagnostic. Specifically, section 4104(c)(2) of the Affordable Care Act waives the Part B deductible with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46317), we proposed that all surgical services furnished on the same date as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema be viewed as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test. We stated in the proposed rule that we believe this interpretation is appropriate because we believe that it would be very rare for an unrelated surgery to occur on the same date as one of these scheduled screening tests. Moreover, we believe that the risk of improper expenditures would be very small under this policy because it is the deductible, and not the coinsurance, that is waived for the related procedures other than the screening tests. In the event of a legislative change to this policy (for example, a statutory change that would waive the coinsurance for these related services in addition to the deductible), we stated that we would reassess the appropriateness of the proposed definition of services that are furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test that becomes diagnostic. We also noted that the annual deductible would likely be met when any surgical procedure (related or not) is performed on the same day as the scheduled screening test.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46317), we proposed to implement this provision by creating a HCPCS modifier that providers would append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic

service. The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance or copayment would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

Comment: Several commenters supported CMS' proposal to extend the waiver of the deductible to surgical services provided on the same date as a colorectal cancer screening test, such as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema, when these become diagnostic. The commenters supported the proposed creation of a HCPCS modifier that would be appended to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service.

One commenter disagreed with CMS' proposal, arguing that CMS' definition of services furnished in connection with or in relation to a colorectal cancer screening test that becomes diagnostic or therapeutic as any and all surgical procedures performed on the same date was too broad, and asked that CMS clarify its policy to exclude the services that are not directly linked to the colorectal cancer screening test. Another commenter requested that CMS seek authority under section 4104 of the Affordable Care Act to waive coinsurance for a colorectal cancer screening test, regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test, or at a minimum waive the coinsurance requirement for the increment of the procedure that is screening in nature.

Response: We appreciate the commenters' support of our proposal to extend the waiver of the deductible to surgical services provided on the same date as a colorectal cancer screening test, such as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema, when these become diagnostic and to create a HCPCS modifier that would be appended to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service.

We do not agree with the commenter that recognizing all surgical procedures performed on the same date as the colorectal cancer screening that becomes diagnostic or therapeutic as being furnished in connection with or in relation to the screening test is too broad, because we believe it is highly unlikely that an unrelated surgery would take place on the same day as a scheduled screening test. We note that section 4104 of the Affordable Care Act only grants us the authority to waive the deductible for a colorectal cancer screening test when it is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test and does not grant us the authority to waive the coinsurance in such cases. A statutory change would be required to waive the Part B coinsurance for a colorectal cancer screening test that becomes diagnostic or therapeutic.

After consideration of the public comments we received, we are finalizing our proposal, without modification, that all surgical services furnished on the same date as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema be viewed as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test for purposes of implementing section 4104(c)(2) of the Affordable Care Act. We are creating new HCPCS modifier PT, effective January 1, 2011, that providers will append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service.

C. Payment for Pulmonary Rehabilitation, Cardiac Rehabilitation, and Intensive Cardiac Rehabilitation Services Furnished to Hospital Outpatients

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60566 through 60574), we addressed the provisions of section 144(a) of the Medicare Improvements for Patients and Providers Act (MIPPA, Pub. L. 110–275). Section 144(a) provided for Medicare Part B coverage and payment for pulmonary and cardiac rehabilitation services, effective January 1, 2010. Medicare Part B coverage is provided for items and services under a cardiac rehabilitation (CR) program, a pulmonary rehabilitation (PR) program, and an intensive cardiac rehabilitation (ICR) program furnished in a physician's office, a hospital on an outpatient basis, or in other settings as the Secretary determines appropriate. We have received questions as to whether a CAH outpatient department is a covered setting for services furnished under these programs because the amendments made to the Act by section 144(a) of the MMA do not specifically define CAHs as hospitals for this benefit.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46317), we clarified that a CAH outpatient department is considered a covered setting for PR, CR, and ICR programs, provided that the programs meet all of the regulatory requirements including, but not limited to, direct supervision of all services by a physician as specified in 42 CFR 410.27(a)(1)(iv)(A). We can establish that CAHs are a covered setting because the law and implementing regulations specify that PR, CR, and ICR services are covered in the hospital outpatient setting, and we define a hospital outpatient in the regulations and program instructions as "a person * * * who * * * receives services * * * directly from the hospital or CAH" (42 CFR 410.2 and the Medicare Benefit Policy Manual, Chapter 6, Section 20.2, available at the CMS Web site at: *http://www.cms.gov/manuals/Downloads/bp102c06.pdf*). We also noted that under section 1861(e) of the Act, the context of the term "hospital" as used in the coverage provisions for PR, CR, and ICR reflects the inclusion of CAHs.

We did not receive any public comments on our clarification of this policy as finalized in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60566 through 60574).

D. Expansion of Multiple Procedure Payment Reduction Under the Medicare Physician Fee Schedule (MPFS) to Therapy Services

Hospitals are paid for outpatient physical therapy (which includes speech language pathology services) and outpatient occupational therapy under the Medicare Physician Fee Schedule (MPFS). Outpatient physical therapy (which includes speech language pathology services) and outpatient occupational therapy services, as described in section 1833(a)(8) of the Act, are excluded from the OPPS by section 1833(t)(1)(B)(iv) of the Act. Section 1833(a)(8) of the Act provides that outpatient physical and occupational therapy are to be paid as provided in section 1834(k) of the Act.

Section 1834(k)(3) of the Act specifies that these services are paid under the fee schedule established under section 1848 of the Act, and section 1848 of the Act establishes payment under the MPFS.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46317), we noted that we proposed to revise the MPFS to apply a multiple procedure payment reduction to payment for all outpatient physical and occupational therapy services paid under the MPFS. We indicated that this proposal was contained in the CY 2011 MPFS proposed rule (CMS–1503–P) (75 FR 40075). To be considered in the development of the final policy for CY 2011, individuals were instructed to submit public comments on this issue in response to the CY 2011 MPFS proposed rule.

As we stated in the CY 2011 OPPS/ASC proposed rule, our proposal to expand the multiple procedure payment reduction under the MPFS to therapy services was included in the CY 2011 MPFS proposed rule because payment to hospitals for outpatient therapy services is made under the MPFS. We refer readers to the CY 2011 MPFS final rule with comment period for our discussion of public comments we received and for the statement of CMS policy in this regard for CY 2011.

XIII. OPPS Payment Status and Comment Indicators

A. OPPS Payment Status Indicator Definitions

Payment status indicators (SIs) that we assign to HCPCS codes and APCs play an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. The final CY 2011 status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively, to this final rule with comment period.

As we proposed in the CY 2011 OPPS/ASC proposed rule (75 FR 46317 through 46321), for CY 2011, we are not making any changes to the status indicators that were listed in Addendum D1 of the CY 2010 OPPS/ASC final rule with comment period. The final status indicators are listed in the tables under sections XIII.A.1., 2., 3., and 4. of this final rule with comment period.

1. Payment Status Indicators to Designate Services That Are Paid Under the OPPS

Indicator	Item/code/service	OPPS payment status
G	Pass-Through Drugs and Biologicals	Paid under OPPS; separate APC payment.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to copayment.
K	Nonpass-Through Drugs and Nonimplantable Biologicals, including Therapeutic Radiopharmaceuticals.	Paid under OPPS; separate APC payment.
N	Items and Services Packaged into APC Rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; per diem APC payment.
Q1	STVX–Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S," "T," "V," or "X." (2) In all other circumstances, payment is made through a separate APC payment.
Q2	T–Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T." (2) In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service. (2) In all other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
R	Blood and Blood Products	Paid under OPPS; separate APC payment.
S	Significant Procedure, Not Discounted When Multiple.	Paid under OPPS; separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; separate APC payment.
U	Brachytherapy Sources	Paid under OPPS; separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; separate APC payment.
X	Ancillary Services	Paid under OPPS; separate APC payment.

Section 142 of Public Law 110–275 (MIPPA) required CMS to pay for therapeutic radiopharmaceuticals for the period of July 1, 2008, through December 31, 2009, at hospitals' charges adjusted to the costs. The status indicator "H" was assigned to therapeutic radiopharmaceuticals to indicate that an item was paid at charges adjusted to cost during CY 2009. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60593), we changed our policy to pay prospectively and separately for therapeutic radiopharmaceuticals with average per day costs greater than the CY 2010 drug packaging threshold of $65 under the OPPS. Therefore, we changed the status indicator for HCPCS codes used to report separately payable therapeutic radiopharmaceuticals from "H" to "K," which indicated that an item is separately paid under the OPPS at the APC payment rate established for the item. We refer readers to section V.B.5. of the CY 2010 OPPS/ASC final rule with comment period for discussion of

the final CY 2010 changes to our payment policy for therapeutic radiopharmaceuticals (74 FR 60593). For CY 2011 OPPS, as we proposed, we are continuing to pay for therapeutic radiopharmaceuticals under the OPPS at the APC payment rate established for the item. (We refer readers to our discussion of payment of therapeutic radiopharmaceuticals in section V.B.3. of this final rule with comment period.)

For CY 2010, we established a policy to consider implantable biologicals that are not on pass-through status as a biological before January 1, 2010, as devices for pass-through evaluation and payment beginning in CY 2010. Therefore, pass-through implantable biologicals were assigned a status indicator of "H," while nonpass-through implantable biologicals were assigned a status indicator of "N" beginning in CY 2010. Those implantable biologicals that have been granted pass-through status under the drug and biological criteria prior to January 1, 2010, continued to be assigned a status indicator of "G" until they are proposed for expiration from pass-through status during our annual rulemaking cycle. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60593), we assigned status indicator "K" to nonimplantable biologicals and adjusted the definition of status indicator "K" accordingly. As we proposed, for CY 2011, we are not making any changes to current policy. We discuss our treatment of drugs, biologicals, and radiopharmaceuticals with new or continuing pass-through status in CY 2011 in section V.A.3. of this final rule with comment period, and we discuss our treatment of drugs and biologicals with expiring pass-through status in CY 2010 including the specific implantable biologicals to which this policy applies for CY 2011 OPPS in section V.A.2. of this final rule with comment period.

We did not receive any public comments regarding definitions of the payment status indicators that designate services that are paid under the OPPS. Therefore, for the reasons set forth in the proposed rule (75 FR 46318), we are finalizing our CY 2011 proposal to continue the current definitions without modification.

The CY 2011 final status indicators are displayed in both the table above and in Addendum D1 to this final rule with comment period.

2. Payment Status Indicators To Designate Services That Are Paid Under a Payment System Other Than the OPPS

We did not propose to make any changes to the status indicators listed below for the CY 2011 OPPS.

Indicator	Item/Code/Service	OPPS payment status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example:	Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS.
	• Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital • Diagnostic Mammography	Not subject to deductible or coinsurance.
	• Screening Mammography	Not subject to deductible.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
F	Corneal Tissue Acquisition; Certain CRNA Services; and Hepatitis B Vaccines.	Not paid under OPPS. Paid at reasonable cost.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary/MAC.	Not paid under OPPS.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

We did not receive any public comments related to payment status indicators that designate services that are paid under a payment system other than the OPPS. Therefore, for the reasons set forth in the proposed rule (75 FR 46320), we are finalizing our CY 2011 proposal without modification.

The CY 2011 final status indicators displayed in the table above are also displayed in Addendum D1 to this final rule with comment period.

3. Payment Status Indicators to Designate Services That Are Not Recognized under the OPPS But That May Be Recognized by Other Institutional Providers

We did not propose changes to the status indicators listed below for the CY 2011 OPPS.

Indicator	Item/Code/Service	OPPS payment status
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS.
		• May be paid by fiscal intermediaries/MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS.
		• An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.

We did not receive any public comments regarding payment status indicators that designate services that are not recognized under the OPPS but that may be recognized by other institutional providers. Therefore, for the reasons set forth in the proposed rule (75 FR 46320), we are finalizing, without modification, our CY 2011 proposal. The final status indicators listed in the table above are also displayed in Addendum D1 to this final rule with comment period.

4. Payment Status Indicators To Designate Services That Are Not Payable by Medicare on Outpatient Claims

We did not propose changes to the payment status indicators listed below for the CY 2011 OPPS.

Indicator	Item/Code/Service	OPPS payment status
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: • That are not covered by any Medicare outpatient benefit based on statutory exclusion.. • That are not covered by any Medicare outpatient benefit for reasons other than statutory exclusion.. • That are not recognized by Medicare for outpatient claims; alternate code for the same item or service may be available.. • For which separate payment is not provided on outpatient claims..	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).

We did not receive any public comments related to payment status indicators that designate services that are not payable by Medicare on outpatient claims. Therefore, for the reasons set forth in the proposed rule (75 FR 46320), we are finalizing, without modification, our proposal for CY 2011. The final status indicators listed in the table above are also displayed in Addendum D1 to this final rule with comment period.

Addendum B, with a complete listing of HCPCS codes including final payment status indicators for each code and final APC assignments for CY 2011, is available electronically on the CMS Web site under supporting documentation for this final rule with comment period at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.*

B. Comment Indicator Definitions

As we proposed in the CY 2011 OPPS/ASC proposed rule (75 FR 46321 and 46322), for the CY 2011 OPPS, we are using the same two comment indicators that are in effect for the CY 2010 OPPS.

• "CH"—Active HCPCS codes in current and next calendar year; status indicator and/or APC assignment have changed or active HCPCS code that will be discontinued at the end of the current calendar year.

• "NI"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year as compared to current calendar year, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.

We proposed in the CY 2011 OPPS/ASC proposed rule (75 FR 46321), to use the "CH" comment indicator in this CY 2011 OPPS/ASC final rule with comment period to indicate HCPCS codes for which the status indicator or APC assignment, or both, will change in CY 2011 compared to their assignment in the current year.

We believe that using the "CH" indicator in this CY 2011 OPPS/ASC final rule with comment period facilitates the public's review of the changes that we are making for CY 2011. The use of the comment indicator "CH" in association with a composite APC indicates that the configuration of the composite APC is changed in this CY 2011 OPPS/ASC final rule with comment period.

We did not propose any changes to our policy regarding the use of comment indicator "NI."

Any existing HCPCS code numbers with substantial revisions to the code descriptors for CY 2011, compared to the CY 2010 descriptors, such that we consider them to describe a new service or procedures for which their OPPS treatment may change, are labeled with comment indicator "NI" in Addendum B to this CY 2011 OPPS/ASC final rule with comment period. We use comment indicator "NI" to indicate that these HCPCS codes are open to comment on this final rule with comment period. Like all codes labeled with comment indicator "NI," we will respond to public comments and finalize their OPPS treatment in the CY 2012 OPPS/ASC final rule with comment period.

In accordance with our usual practice, CPT and Level II HCPCS code numbers that are new for CY 2011 are also be labeled with comment indicator "NI" in Addendum B to this CY 2011 OPPS/ASC final rule with comment period.

Only HCPCS codes with comment indicator "NI" in this CY 2011 OPPS/ASC final rule with comment period are subject to comment. HCPCS codes that do not appear with comment indicator "NI" in this CY 2011 OPPS/ASC final rule with comment period are not be open to public comment, unless we specifically request additional comments elsewhere in this final rule with comment period. The CY 2011 treatment of HCPCS codes that appears in this CY 2011 OPPS/ASC final rule with comment period to which comment indicator "NI" is not appended were opened to public comment during the comment period for the proposed rule, and we are responding to those comments in this final rule with comment period.

We did not receive any public comments on the proposed comment indicators. Therefore, for the reasons set forth in the proposed rule (75 FR 46321 and 46322), we are finalizing, without modification, our CY 2011 proposal and are continuing to use comment indicators "CH" and "NI" for CY 2011. Their definitions are listed in Addendum D2 to this final rule with comment period.

XIV. OPPS Policy and Payment Recommendations

A. MedPAC Recommendations

MedPAC was established under section 1805 of the Act to advise the U.S. Congress on issues affecting the Medicare program. As required under the statute, MedPAC submits reports to Congress not later than March and June of each year that contain its Medicare

payment policy recommendations. This section describes recent recommendations relevant to the OPPS that have been made by MedPAC.

The March 1, 2010 MedPAC "Report to Congress: Medicare Payment Policy" included the following recommendation relating specifically to the Medicare hospital OPPS:

Recommendation 2A–1: The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2011 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.

CMS Response: Subsequent to the issuance of the MedPAC report, Congress enacted the Affordable Care Act. Section 1833(t)(3)(F) of the Act, as added by section 3401 of the Affordable Care Act and as amended by section 10319 of the Affordable Care Act and section 1105 of the HCERA, provides that after determining the OPD fee schedule increase factor, the Secretary shall reduce such increase factor by a 0.25 percentage point in 2011. As discussed in section II.B. of this final rule with comment period, we are increasing the full CY 2011 conversion factor by the projected rate of increase in the hospital market basket less the mandated 0.25 percentage point reduction. Simultaneously, for CY 2011, as proposed, we are reducing the annual update factor by 2.0 percentage points for hospitals that are defined under section 1886(d)(1)(B) of the Act and that do not meet the hospital outpatient quality data reporting required by section 1833(t)(17) of the Act. We are making this adjustment after the application of the 0.25 percentage point reduction. For the adjustment under section 1833(t)(17) of the Act, as proposed, for this final rule with commenter period, we calculated two conversion factors: A full conversion factor based on the annual update factor, adjusted by the 0.25 percentage point reduction required by the Affordable Care Act for CY 2011; and a reduced conversion factor that reflects the 2.0 percentage points reduction to the annual update factor, as adjusted by the 0.25 percentage point reduction. CMS implemented the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) in CY 2008 and is continuing this program in CY 2011 (as discussed in section XVI. of this final rule with comment period).

The full March 1, 2010 MedPAC report can be downloaded from MedPAC's Web site at: *http://www.medpac.gov/documents/Mar10_EntireReport.pdf.*

On June 15, 2010, MedPAC issued a report to Congress titled "Aligning Incentives in Medicare." The June 15, 2010 MedPAC report did not contain any recommendations that pertain to the OPPS. The June 15, 2010 MedPAC report can be downloaded from MedPAC's Web site at: *http://www.medpac.gov/documents/Jun10_EntireReport.pdf*

B. APC Panel Recommendations

Recommendations made by the APC Panel at its February 2010 and August 2010 meetings are discussed in the sections of this final rule with comment period that correspond to topics addressed by the APC Panel. The reports and recommendations from the APC Panel's February and August 2010 meetings regarding payment under the OPPS for CY 2011 are available on the CMS Web site at: *http://www.cms.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp.*

C. OIG Recommendations

The mission of the Office of the Inspector General (OIG), as mandated by Public Law 95–452, as amended, is to protect the integrity of the U.S. Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections. On October 22, 2010, the OIG published memorandum report "Payment for Drugs Under the Hospital Outpatient Prospective Payment System," OIG–03–09–00420. The report may be viewed at *http://oig.hhs.gov/oei/reports/oei-03-09-00420.pdf.* CMS has begun evaluating the recommendations contained in this report.

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

A. Background

1. Legislative Authority for the ASC Payment System

Section 1832(a)(2)(F)(i) of the Act provides that benefits under Medicare Part B include payment for facility services furnished in connection with surgical procedures specified by the Secretary that are performed in an Ambulatory Surgical Center (ASC). To participate in the Medicare program as an ASC, a facility must meet the standards specified in section 1832(a)(2)(F)(i) of the Act, which are set forth in 42 CFR Part 416, Subpart B and Subpart C of our regulations. The regulations at 42 CFR Part 416, Subpart B describe the general conditions and requirements for ASCs, and the regulations at Subpart C explain the specific conditions for coverage for ASCs.

Section 141(b) of the Social Security Act Amendments of 1994, Public Law 103–432, required establishment of a process for reviewing the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for intraocular lenses (IOLs) that belong to a class of new technology intraocular lenses (NTIOLs). That process was the subject of a final rule entitled "Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers," published on June 16, 1999, in the **Federal Register** (64 FR 32198).

Section 626(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, added subparagraph (D) to section 1833(i)(2) of the Act, which required the Secretary to implement a revised ASC payment system to be effective not later than January 1, 2008. Section 626(c) of the MMA amended section 1833(a)(1) of the Act by adding new subparagraph (G), which requires that, beginning with implementation of the revised ASC payment system, payment for surgical procedures furnished in ASCs shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under the revised payment system.

Section 5103 of the Deficit Reduction Act of 2005 (DRA), Public Law 109–171, amended section 1833(i)(2) of the Act by adding new subparagraph (E) to place a limitation on payment amounts for surgical procedures furnished in ASCs on or after January 1, 2007, but before the effective date of the revised ASC payment system (that is, January 1, 2008). Section 1833(i)(2)(E) of the Act provides that if the standard overhead amount under section 1833(i)(2)(A) of the Act for an ASC facility service for such surgical procedures, without application of any geographic adjustment, exceeds the Medicare payment amount under the hospital OPPS for the service for that year, without application of any geographic adjustment, the Secretary shall substitute the OPPS payment amount for the ASC standard overhead amount.

Section 109(b) of the Medicare Improvements and Extension Act of 2006 of the Tax Relief and Health Care Act of 2006 (MIEA–TRHCA), Public Law 109–432, amended section 1833(i)(2)(D) of the Act, in part, by redesignating clause (iv) as clause (v) and adding a new clause (iv) and by

adding new section 1833(i)(7)(A). These amendments provide the Secretary the authority to require ASCs to submit data on quality measures and to reduce the annual update by 2 percentage points for an ASC that fails to submit data as required by the Secretary on selected quality measures. Section 109(b) of the MIEA–TRHCA also amended section 1833(i) of the Act by adding new section 1833(i)(7)(B), which requires that, to the extent the Secretary establishes such an ASC quality reporting program, certain quality of care reporting requirements mandated for hospitals paid under the OPPS, under sections 1833(t)(17)(B), (C), (D) and (E) of the Act, as added by section 109(a) of the MIEA–TRHCA, be applied in a similar manner to ASCs unless otherwise specified by the Secretary.

Sections 4104 and 10406 of the Affordable Care Act, Public Law 111–148, amend sections 1833(a)(1) and (b)(1) of the Act to waive the coinsurance and the Part B deductible for those preventive services under section 1861(ddd)(3)(A) of the Act as described in section 1861(ww)(2) of the Act (excluding electrocardiograms) that are recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual. Section 4104(c) of the Affordable Care Act amends section 1833(b)(1) of the Act to waive the Part B deductible for colorectal cancer screening tests that become diagnostic. These provisions apply to these items and services furnished in an ASC on or after January 1, 2011.

Section 3401(k) of the Affordable Care Act amends section 1833(i)(2)(D) of the Act to require that, effective for CY 2011 and subsequent years, any annual update under the ASC payment system be reduced by a productivity adjustment, which is equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period). Application of this productivity adjustment to the ASC payment system may result in the update to the ASC payment system being less than zero for a year and may result in payment rates under the ASC payment system for a year being less than such payment rates for the preceding year.

For a detailed discussion of the legislative history related to ASCs, we refer readers to the June 12, 1998 proposed rule (63 FR 32291 through 32292).

2. Prior Rulemaking

On August 2, 2007, we published in the **Federal Register** (72 FR 42470) the final rule for the revised ASC payment system, effective January 1, 2008 (the "August 2, 2007 final rule"). In that final rule, we revised our criteria for identifying surgical procedures that are eligible for Medicare payment when furnished in ASCs and adopted the method we would use to set payment rates for ASC covered surgical procedures and covered ancillary services furnished in association with those covered surgical procedures beginning in CY 2008. We also established a policy for treating new and revised HCPCS and CPT codes (Physicians' Current Procedural Terminology) under the ASC payment system. This policy is consistent with the OPPS to the extent possible (72 FR 42533). Additionally, we established a standard ASC ratesetting methodology that bases payment for most services on the list of ASC covered surgical procedures on the OPPS relative payment weight multiplied by an ASC conversion factor. We also established modifications to this methodology for subsets of services, such as device-intensive services (where the estimated device portion of the ASC payment is the same as that paid under the OPPS) and services that are predominantly performed in the office setting and covered ancillary radiology services (where ASC payment may be based on the MPFS non-facility practice expense (PE) Relative Value Units (RVUs)). Additionally, we established a policy for updating the conversion factor, the relative payment weights, and the ASC payment rates on an annual basis. We also annually update the list of procedures for which Medicare would not make an ASC payment.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66827), we updated and finalized the CY 2008 ASC rates and lists of covered surgical procedures and covered ancillary services. We also made regulatory changes to 42 CFR Parts 411, 414, and 416 related to our final policies to provide payments to physicians who perform noncovered ASC procedures in ASCs based on the facility PE RVUs, to exclude covered ancillary radiology services and covered ancillary drugs and biologicals from the categories of designated health services (DHS) that are subject to the physician self-referral prohibition, and to reduce ASC payments for surgical procedures when the ASC receives full or partial credit toward the cost of the implantable device. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68722), we updated and finalized the CY 2009 ASC rates and lists of covered surgical procedures and covered ancillary services.

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60596), we updated and finalized the CY 2010 ASC rates and lists of covered surgical procedures and covered ancillary services. We also corrected some of those ASC rates in a correction notice published in the **Federal Register** on December 31, 2009 (74 FR 69502). In that correction notice, we revised the ASC rates to reflect changes in the MPFS conversion factor and PE RVUs listed for some CPT codes in Addendum B to the CY 2010 MPFS final rule with comment period (74 FR 62017), which were incorrect due to methodological errors and, consequently, were corrected in a correction notice to that final rule with comment period (74 FR 65449). We also published a second correction notice in the **Federal Register**, to address changes to the ASC rates resulting from corrections to the PE RVUs identified subsequent to publication of the December 31, 2009 correction notice (75 FR 45700). Finally, we published a notice in the **Federal Register**, to reflect changes to CY 2010 ASC payment rates for certain ASC services due to changes to the OPPS and MPFS under the Affordable Care Act and to reflect technical changes to the ASC payment rates announced in prior correction notices (75 FR 45769).

3. Policies Governing Changes to the Lists of Codes and Payment Rates for ASC Covered Surgical Procedures and Covered Ancillary Services

The August 2, 2007 final rule established our policies for determining which procedures are ASC covered surgical procedures and covered ancillary services. Under §§ 416.2 and 416.166 of the regulations, subject to certain exclusions, covered surgical procedures are surgical procedures that are separately paid under the OPPS, that would not be expected to pose a significant risk to beneficiary safety when performed in an ASC, and that would not be expected to require active medical monitoring and care at midnight following the procedure ("overnight stay"). We adopted this standard for defining which surgical procedures are covered surgical procedures under the ASC payment system as an indicator of the complexity of the procedure and its appropriateness for Medicare payment in ASCs. We use this standard only for purposes of

evaluating procedures to determine whether or not they are appropriate for Medicare beneficiaries in ASCs. We define surgical procedures as those described by Category I Current Procedural Terminology (CPT) codes in the surgical range from 10000 through 69999, as well as those Category III CPT codes and Level II Healthcare Common Procedure Coding System (HCPCS) codes that crosswalk or are clinically similar to ASC covered surgical procedures (72 FR 42478). We note that we added over 800 surgical procedures to the list of covered surgical procedures for ASC payment in CY 2008, the first year of the revised ASC payment system, based on the criteria for payment that we adopted in the August 2, 2007 final rule as described above in this section. Patient safety and health outcomes continue to be important to us as more health care moves to the ambulatory care setting. Therefore, as we gain additional experience with the ASC payment system, we are interested in any information the public may have regarding the comparative patient outcomes of surgical care provided in ambulatory settings, including HOPDs, ASCs, and physicians' offices, particularly with regard to the Medicare population.

In the August 2, 2007 final rule, we also established our policy to make separate ASC payments for the following ancillary items and services when they are provided integral to ASC covered surgical procedures: Brachytherapy sources; certain implantable items that have pass-through status under the OPPS; certain items and services that we designate as contractor-priced, including, but not limited to, procurement of corneal tissue; certain drugs and biologicals for which separate payment is allowed under the OPPS; and certain radiology services for which separate payment is allowed under the OPPS. These covered ancillary services are specified in § 416.164(b) and, as stated previously, are eligible for separate ASC payment (72 FR 42495). Payment for ancillary items and services that are not paid separately under the ASC payment system is packaged into the ASC payment for the covered surgical procedure.

We update the lists of, and payment rates for, covered surgical procedures and covered ancillary services, in conjunction with the annual proposed and final rulemaking process to update the OPPS and the ASC payment system (§ 416.173; 72 FR 42535). In addition, as discussed in detail below in section XV.B., because we base ASC payment policies for covered surgical procedures, drugs, biologicals, and certain other covered ancillary services on the OPPS payment policies, we also provide quarterly updates for ASC services throughout the year (January, April, July, and October), just as we do for the OPPS. The updates are to implement newly created Level II HCPCS and Category III CPT codes for ASC payment and to update the payment rates for separately paid drugs and biologicals based on the most recently submitted ASP data. New Category I CPT codes, except vaccine codes, are released only once a year and, therefore, are implemented through the January quarterly update. New Category I CPT vaccine codes are released twice a year and thus are implemented through the January and July quarterly updates.

In our annual updates to the ASC list of, and payment rates for, covered surgical procedures and covered ancillary services, we undertake a review of excluded surgical procedures (including all procedures newly proposed for removal from the OPPS inpatient list), new procedures, and procedures for which there is revised coding, to identify any that we believe meet the criteria for designation as ASC covered surgical procedures or covered ancillary services. Updating the lists of covered surgical procedures and covered ancillary services, as well as their payment rates, in association with the annual OPPS rulemaking cycle is particularly important because the OPPS relative payment weights and, in some cases, payment rates, are used as the basis for the payment of covered surgical procedures and covered ancillary services under the revised ASC payment system. This joint update process ensures that the ASC updates occur in a regular, predictable, and timely manner.

Comment: Several commenters provided a number of general suggestions related to the ASC list of covered surgical procedures. They contended that CMS should not restrict which procedures are payable in ASCs any more than CMS restricts which procedures are payable in HOPDs. According to the commenters, when CMS declines to add a service to the ASC list that can be performed in hospitals and physician offices, CMS should articulate a clinical rationale for why the procedure should be excluded from the ASC setting. They also stated that CMS should use as one of its evaluation measures for additions to the ASC list the number of procedures performed in the office setting. Some commenters urged CMS to eliminate unlisted codes from the exclusionary criteria at § 416.166(c), and other commenters requested that ASCs be allowed to use unlisted codes to bill for procedures that are from anatomic sites that could not possibly pose a potential risk to beneficiary safety. The commenters reported that unlisted codes enable surgeons to utilize innovative techniques or new technologies and are paid under the OPPS and by commercial insurers. They suggested that ASCs could provide documentation to the contractor that explains and justifies the procedure reported by an unlisted code; thus ensuring that Medicare does not make payment for a service that would otherwise be excluded from payment.

Response: We appreciate the commenters' suggestions related to our decisions about which procedures are excluded from the ASC list of covered surgical procedures. However, as we explained in the August 2, 2007 final rule (72 FR 42479), we do not believe that all procedures that are appropriate for performance in HOPDs are appropriate in ASCs. 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. 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 modifying our policy and will continue to exclude certain procedures for which payment is made in HOPDs from the ASC list of covered surgical procedures.

We do not agree with the commenters' request that we provide specific reasons for our decisions to exclude each procedure from the ASC list of covered surgical procedures. Our decisions to exclude procedures from the ASC list are based on a number of the criteria listed at § 416.166 of the regulations, and we believe that it would be unnecessary and overly burdensome to list each reason for those decisions. As we have stated in the past (74 FR 60598), we continue to believe that these reasons are sufficiently specific to enable the public to provide meaningful comments on our decisions to exclude procedures from the list of covered surgical procedures. In response to the commenter's request that we use as one of our evaluation measures for additions to the ASC list the number of procedures performed in the office setting, we note that the criteria listed in § 416.166 do not include the number of procedures done in the office setting. We also do not agree with the

commenters' recommendation that we include certain unlisted codes on the list of covered procedures. Even though it may be highly unlikely that any procedures that would be expected to pose a significant risk to beneficiary safety when performed in an ASC or expected to require an overnight stay would be reported by an unlisted code from certain anatomic sites, we cannot know what surgical procedure is being reported by an unlisted code. Therefore, as we have explained in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60598), because we cannot evaluate any such procedure, we continue to believe that we must exclude unlisted codes as a group from the list of covered surgical procedures. We also do not believe it is reasonable, or within the scope of our contractors' work, to accept the commenters' suggestion that ASCs could provide documentation to our Medicare contractors in order for the contractors to make a determination about whether or not a procedure that was billed using an unlisted code represented a significant risk to beneficiary safety or would be expected to require an overnight stay.

After consideration of the public comments we received, we are continuing our established policies without modification for determining which procedures are ASC covered surgical procedures and covered ancillary services.

B. Treatment of New Codes

1. Process for Recognizing New Category I and Category III CPT Codes and Level II HCPCS Codes

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

We finalized a policy in the August 2, 2007 final rule to evaluate each year all new Category I and Category III CPT codes and Level II HCPCS codes that describe surgical procedures, and to make preliminary determinations in the annual OPPS/ASC final rule with comment period regarding whether or not they meet the criteria for payment in the ASC setting as covered surgical procedures and, if so, whether they are office-based procedures (72 FR 42533 through 42535). In addition, we identify new codes as ASC covered ancillary services based upon the final payment policies of the revised ASC payment system.

In Table 39 of the CY 2011 OPPS/ASC proposed rule (75 FR 46325), we summarized our proposed process for updating the HCPCS codes recognized under the ASC payment system.

This process is discussed in detail below and we have separated our discussion based on whether we proposed to solicit public comments in the CY 2011 proposed rule on a specific group of the CPT and Level II HCPCS codes (and respond to those comments in this CY 2011 OPPS/ASC final rule with comment period) or whether we proposed to solicit public comments on another specific group of the codes in this CY 2011 final rule with comment period (and respond to those comments in the CY 2012 OPPS/ASC final rule with comment period). We sought public comments in the CY 2010 OPPS/ASC final rule with comment period on the new CPT and HCPCS codes that were effective January 1, 2010. These new codes were flagged with comment indicator "N1" in Addendum AA and BB to the CY 2010 OPPS/ASC final rule with comment period to indicate that we were assigning them an interim payment status and payment rate, if applicable, which were subject to public comment following publication of the CY 2010 OPPS/ASC final rule with comment period. We stated that we would respond to public comments and finalizing our proposed ASC treatment of these codes in the CY 2011 OPPS/ASC final rule with comment period.

We received no public comments regarding our process for recognizing new HCPCS codes under the ASC payment system and are implementing our proposed policy without modification.

2. Treatment of New Level II HCPCS Codes and Category III CPT Codes Implemented in April and July 2010 for Which We Solicited Public Comments in the CY 2011 OPPS/ASC Proposed Rule

In the April and July CRs, we made effective for April 1 or July 1, 2010, a total of 14 new Level II HCPCS codes and 7 new Category III CPT codes that were not addressed in the CY 2010 OPPS/ASC final rule with comment period. (We note that one Level II HCPCS code that was added in the April 2010 CR, C9262, was deleted June 30, 2010, and replaced with Q2025 effective July 1, 2010). The 13 new Level II HCPCS codes describe covered ancillary services.

Through the April 2010 ASC quarterly update (Transmittal 1943, CR 6866, dated April 6, 2010), we added six new drug and biological Level II HCPCS codes to the list of covered ancillary services. Specifically, as displayed in Table 40 of the CY 2011 OPPS/ASC proposed rule (75 FR 46327), these included HCPCS codes C9258 (Injection, telavancin, 10 mg), C9259 (Injection, pralatrexate, 1 mg), C9260 (Injection, ofatumumab, 10 mg), C9261 (Injection, ustekinumab, 1 mg), C9262 (Fludarabine phosphate, oral, 1 mg), and C9263 (Injection, ecallantide, 1 mg).

Through the July 2010 quarterly update (Transmittal 1984, Change Request 7008, dated June 11, 2010), we added seven new drug and biological Level II HCPCS codes to the list of covered ancillary services. Specifically, as displayed in Table 41 of the CY 2011 OPPS/ASC proposed rule (75 FR 46327), we provided separate payment for HCPCS codes C9264 (Injection, tocilizumab, 1 mg), C9265 (Injection, romidepsin, 1 mg), C9266 (Injection, collagenase clostridium histolyticum, 0.1 mg), C9267 (Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO), C9268 (Capsaicin, patch, 10cm2), C9367 (Skin substitute, Endoform Dermal Template, per square centimeter), and Q2025 (Fludarabine phosphate oral, 10 mg). As noted above, HCPCS code C9262 was made effective April 1, 2010, and

deleted June 30, 2010, when it was replaced with HCPCS code Q2025.

We assigned payment indicator "K2" (Drugs and biologicals paid separately when provided integral to a surgical procedure on the ASC list; payment based on OPPS rate) to these 13 new Level II HCPCS codes to indicate that they are separately paid when provided in ASCs. In the CY 2011 OPPS/ASC proposed rule, we solicited public comment on the proposed CY 2010 ASC payment indicators and payment rates for the drugs and biologicals, as listed in Tables 40 and 41 of the CY 2011 OPPS/ASC proposed rule (75 FR 46326 through 46327). Those HCPCS codes became payable in ASCs, beginning in April or July 2010, and are paid at the ASC rates posted for the appropriate calendar quarter on the CMS Web site at *http://www.cms.gov/ASCPayment/*.

The HCPCS codes listed in Table 40 were included in Addendum BB to the CY 2011 OPPS/ASC proposed rule. (We note that Level II HCPCS code C9262 was deleted June 30, 2010, and replaced with Q2025 effective July 1, 2010, and therefore was not included in Addendum BB and was not open to public comment. Instead, Level II HCPCS code Q2025 was open for public comment.)

However, because HCPCS codes that became effective for July (listed in Table 41 of the CY 2011 OPPS/ASC proposed rule) were not available to us in time for incorporation into the Addenda to the OPPS/ASC proposed rule, our policy is to include these HCPCS codes and their proposed payment indicators and payment rates in the preamble to the proposed rule but not in the Addenda to the proposed rule. These codes and their final payment indicators and rates are included in the appropriate Addendum to this CY 2011 OPPS/ASC final rule with comment period. Thus, the codes implemented by the July 2010 ASC quarterly update CR and their proposed CY 2011 payment rates (based on July 2010 ASP data) that were displayed in Table 41 of the CY 2011 OPPS/ASC proposed rule were not included in Addendum BB to that proposed rule. We proposed to include these services reported using the new Level II HCPCS codes displayed in Tables 40 and 41 of the CY 2011 OPPS/ASC proposed rule (75 FR 46327) as covered ancillary services for payment to ASCs for CY 2011. The final list of covered ancillary services and the associated payment weights and payment indicators is included in Addendum BB to this CY 2011 OPPS/ASC final rule with comment period, consistent with our annual update policy. We solicited public comments on these proposed payment indicators and the payment rates, if any, for the new Level II HCPCS codes that were newly recognized as ASC covered ancillary services in April or July 2010 through the respective quarterly update CRs, as listed in Tables 40 and 41 of the CY 2011 OPPS/ASC proposed rule (75 FR 46327, 46329). We proposed to finalize their payment indicators and their payment rates, if applicable, in this CY 2011 OPPS/ASC final rule with comment period.

We did not receive any public comments regarding our proposals. We are adopting as final the ASC payment indicators for the covered ancillary services described by the new Level II HCPCS codes implemented in April and July 2010 through the respective quarterly update CR as shown below, in Tables 49 and 50, respectively. We note that after publication of the CY 2011 OPPS/ASC proposed rule, the CMS HCPCS Workgroup created permanent HCPCS J-codes for CY 2011 to replace certain temporary HCPCS C-codes made effective for CY 2010. These permanent CY 2011 HCPCS J-codes are listed alongside the temporary CY 2010 HCPCS C-codes in Tables 49 and 50 below. The final payment indicators and payment rates for these codes are displayed in Addendum BB to this final rule with comment period.

TABLE 49—NEW LEVEL II HCPCS CODES FOR COVERED ANCILLARY SERVICES IMPLEMENTED IN APRIL 2010

CY 2011 HCPCS code	CY 2010 HCPCS code	CY 2011 long descriptor	Final CY 2011 payment indicator
J3095	C9258	Injection, telavancin, 10 mg	K2
J9307	C9259	Injection, pralatrexate, 1 mg	K2
J9302	C9260	Injection, ofatumumab, 10 mg	K2
J3357	C9261	Injection, ustekinumab, 1 mg	K2
J8562	C9262*	Fludarabine phosphate, oral, 10 mg	K2
J1290	C9263	Injection, ecallantide, 1 mg	K2

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

TABLE 50—NEW LEVEL II HCPCS CODES FOR COVERED ANCILLARY SERVICES IMPLEMENTED IN JULY 2010

CY 2011 HCPCS code	CY 2010 HCPCS code	CY 2011 long descriptor	Final CY 2011 payment indicator
J3262	C9264	Injection, tocilizumab, 1 mg	K2
J9315	C9265	Injection, romidepsin, 1 mg	K2
J0775	C9266	Injection, collagenase clostridium histolyticum, 0.01 mg	K2
J7184	C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	K2
J7335	C9268	Capsaicin, patch, per 10 square centimeters	K2
C9367	C9367	Skin substitute, Endoform Dermal Template, per square centimeter	K2
J8562	Q2025	Fludarabine phosphate oral, 10 mg	K2

Through the July 2010 quarterly update CR, we also implemented ASC payment for seven new Category III CPT codes and one new Level II HCPCS code as ASC covered surgical procedures, effective July 1, 2010. These codes were listed in Table 42 of the CY 2011 OPPS/ASC proposed rule (75 FR 46328), along with their proposed payment indicators and proposed payment rates for CY 2011. Because new Category III CPT and Level II HCPCS codes that become

effective for July are not available to us in time for incorporation into the Addenda to the OPPS/ASC proposed rule, our policy is to include the codes, their proposed payment indicators, and proposed payment rates in the preamble to the proposed rule but not in the Addenda to the proposed rule. These codes and their final payment indicators and rates are included in the Addenda to this CY 2011 OPPS/ASC final rule with comment period. We solicited public comments on these proposed payment indicators and the payment rates for the new Level II HCPCS code and Category III CPT codes that were newly recognized as ASC covered surgical procedures in the July 2010 through the respective quarterly update CRs, as listed in Table 42 of the CY 2011 OPPS/ASC proposed rule (75 FR 46328 through 46329). We proposed to finalize their payment indicators and their payment rates in this CY 2011 OPPS/ASC final rule with comment period.

Comment: Some commenters asserted that the procedures described by CPT codes 0228T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level), 0229T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)), 0230T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level) and 0231T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)) are using ultrasound without fluoroscopy, which the commenters believed is inappropriate because, according to the commenters, there is no evidence of accurate needle placement or effectiveness for these procedures. The commenters believed that Medicare should not pay for these procedures when they are performed in the ASC setting.

Response: In order for any procedure to be added to the ASC list of covered surgical procedures, the procedure must meet the criteria set forth at 42 CFR 416.166, including that it would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC and it would not be expected to require an overnight stay. After careful medical review of these procedures, our clinical staff has determined that the procedures described by CPT codes 0228T, 0229T, 0230T, and 0213T meet these criteria and may be paid for by Medicare when provided in the ASC setting. Therefore, we disagree with the commenter and will continue to include these CPT codes on the ASC list of covered surgical procedures.

After consideration of the public comments received, for CY 2011, we are continuing our established policy for recognizing new mid-year CPT and HCPCS codes. We also are adopting as final the ASC payment indicators for the covered surgical procedures described by the new Category III CPT codes and the new Level II HCPCS code implemented in the July 2010 CR as shown in Table 51 below and Table 50. The new CPT and HCPCS codes implemented in July 2010 are displayed in Addendum AA to this final rule with comment period as well.

TABLE 51—NEW CATEGORY III CPT CODES AND LEVEL II HCPCS CODE IMPLEMENTED IN JULY 2010 AS ASC COVERED SURGICAL PROCEDURES

CY 2011 HCPCS code	CY 2011 Long descriptor	Final CY 2011 payment indicator **
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed.	R2 *
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	R2 *
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level.	G2
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure).	G2
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level.	G2
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure).	G2
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed.	R2*
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies.	R2 *

* If designation is temporary.

** Payment indicators are based on a comparison of the rates according to the ASC standard ratesetting methodology and the MPFS rates. At the time this final rule with comment period is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this final rule with comment period reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the January 2011 payment rate files issued to contractors and posted to the ASC Web site at *http://www.cms.gov/ASCPayment/.*

3. Process for New Level II HCPCS Codes and Category I and III CPT Codes for Which We Are Soliciting Public Comments in This CY 2011 OPPS/ASC Final Rule With Comment Period

As has been our practice in the past, we incorporate those new Category I and Category III CPT codes and new Level II HCPCS codes that are effective January 1 in the final rule with comment period updating the ASC payment system for the following calendar year. These codes are released to the public via the CMS HCPCS (for Level II HCPCS codes) and AMA Web sites (for CPT codes), and also through the January ASC quarterly update CRs. In the past, we also have released new Level II HCPCS codes that are effective October 1 through the October ASC quarterly update CRs and incorporated these new codes in the final rule with comment period updating the ASC payment system for the following calendar year. All of these codes are flagged with comment indicator "NI" in Addenda AA and BB to the OPPS/ASC

final rule with comment period to indicate that we are assigning them an interim payment status which is subject to public comment. Specifically, the payment indicator and payment rate, if applicable, for all such codes flagged with comment indicator "NI" are open to public comment in the OPPS/ASC final rule with comment period, and we respond to these comments in the final rule with comment period for the next calendar year's OPPS/ASC update. In the CY 2011 OPPS/ASC proposed rule (75 FR 46329), we proposed to continue this process for CY 2011.

For CY 2011, we also proposed to include in Addenda AA and BB to the CY 2011 OPPS/ASC final rule with comment period the new Category I and III CPT codes effective January 1, 2011 (including those Category III CPT codes that were released by the AMA in July 2010) that would be incorporated in the January 2011 ASC quarterly update CR and the new Level II HCPCS codes, effective October 1, 2010 or January 1, 2011, that would be released by CMS in its October 2010 and January 2011 ASC quarterly update CRs. These codes would be flagged with comment indicator "NI" in Addenda AA and BB to this CY 2011 OPPS/ASC final rule with comment period to indicate that we have assigned them an interim payment status. Their payment indicators and payment rates, if applicable, would be open to public comment in the CY 2011 OPPS/ASC final rule with comment period and would be finalized in the CY 2012 OPPS/ASC final rule with comment period.

We did not receive any comments regarding this proposed process. For CY 2011, we are finalizing our proposal, without modification, to continue our established process for recognizing and soliciting public comments on new Level II HCPCS codes and Category I and III CPT codes for the following calendar year, as described above.

C. Update to the Lists of ASC Covered Surgical Procedures and Covered Ancillary Services

1. Covered Surgical Procedures

a. Additions to the List of ASC Covered Surgical Procedures

In the CY 2011 OPPS/ASC proposed rule (75 FR 46329 through 46330), we proposed to update the list of ASC covered surgical procedures by adding five procedures to the list. These five procedures were among those excluded from the ASC list for CY 2010 because we believed they did not meet the definition of a covered surgical procedure based on our expectation that they would pose a significant safety risk to Medicare beneficiaries or would require an overnight stay if performed in ASCs. We conducted a review of all HCPCS codes that currently are paid under the OPPS, but not included on the ASC list of covered surgical procedures, to determine if changes in technology and/or medical practice changed the clinical appropriateness of these procedures for the ASC setting. We determined that these five procedures could be safely performed in the ASC setting and therefore proposed to include them on the list of ASC covered surgical procedures for CY 2011.

The five procedures that we proposed to add to the ASC list of covered surgical procedures, including their HCPCS code long descriptors and proposed CY 2010 payment indicators, were displayed in Table 43 of the CY 2011 OPPS/ASC proposed rule (75 FR 46330). Subsequent to the release of the CY 2011 OPPS/ASC proposed rule, we recognized that the long descriptors for CPT codes 37210 (Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure) and 50593 (Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy) in Table 43 were incorrect. We also realized that CPT code 52649 (Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)) and its payment indicator were missing from Table 43 (the descriptor for CPT code 52649 was listed incorrectly for CPT code 50593). We corrected Table 43 on the CMS Web site for the CY 2011 OPPS/ASC proposed rule at *http://www.cms.gov/ASCPayment/*. Therefore, we proposed to add six procedures (described by CPT codes 37204, 37205, 37206, 37210, 50593, and 52649) to the ASC list of covered surgical procedures for CY 2011.

Since publication of the proposed rule, the CPT Editorial Panel significantly changed the descriptors for two CPT codes we had proposed to add to the list of ASC surgical procedures. The CPT code descriptors previously read as follows: 37205 (Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel) and 37206 (Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel (List separately in addition to code for primary procedure)). After the CPT Editorial Panel change, the CPT descriptors read as follows: 37205 (Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel, and lower extremity arteries), percutaneous; initial vessel) and 37206 (Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)). Because the CPT Editorial Panel changes are effective January 1, 2011, we reevaluated the appropriateness of these procedures in the ASC setting. Based on the review of our clinical staff, we determined that the level of care indicated by the new descriptors for CPT codes 37205 and 37206 make these codes ineligible for payment in the ASC setting because they do not meet the criteria for ASC coverage listed at § 416.166 of the regulations. However, we will recognize as ASC covered surgical procedures two new CY 2011 CPT codes that, prior to January 1, 2011, would have been described in part under the CY 2010 CPT code descriptors for 37205 and 37206. Specifically, we believe that the procedures described by CPT codes 37221 (Revascularization, iliac artery, unilateral, initial vessel; with transluminal stent placement(s)) and 37223 (Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s) (List separately in addition to code for primary procedure)) may be safely performed and would not require an overnight stay in the ASC setting, and that the addition of these procedures to the ASC list of covered surgical procedures in CY 2011 is consistent with our proposal to add CPT codes 37205 and 37206 to the ASC list of covered surgical procedures in CY 2011, because the CPT codes for 37221 and 37223 now describe services that would have been described by CPT codes 37205 and 37206 had the CPT Editorial Panel not changed the descriptors for these codes (as with all new HCPCS codes for the upcoming year that are recognized for payment under the ASC payment system, CPT codes 37221 and 37223 are listed in the Addenda to this final rule with comment period with comment indicator "NI" to indicate that

their payment assignments are interim and open to public comment).

Comment: One commenter reiterated a previous request to remove the hand and cleft lip and palate reconstruction procedures described by the following CPT codes from the ASC list of covered surgical procedures because they believe these procedures are inappropriate for an ASC setting: 21215 (Graft, bone; mandible (includes obtaining graft)); 26037 (Decompressive fasciotomy, hand); 40700 (Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral); 40701 (Plastic repair of cleft lip/nasal deformity, primary bilateral, one stage procedure); 42200 (Palatoplasty for cleft palate, soft and/or hard palate only); 42205 (Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only); 42210 (Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge includes obtaining graft); 42215 (Palatoplasty for cleft palate; major revision); 42220 (Palatoplasty for cleft palate; secondary lengthening procedure); 42225 (Palatoplasty for cleft palate; attachment pharyngeal flap); and 42227 (Lengthening of palate, with island flap).

Response: As we have done in the past, our medical advisors reviewed all these procedures and as a result of that review, we continue to believe that they may be appropriately provided to a Medicare beneficiary in an ASC. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60603), we do not see a basis for removing these procedures from the ASC list as requested by the commenter. All of these procedures were on the list of covered surgical procedures even before CY 2007 and, to our knowledge, have been performed safely in ASCs for many years. We continue to believe that these 11 procedures would not pose a significant safety risk to Medicare beneficiaries and would not require an overnight stay if performed in ASCs.

As established at § 416.166(b), decisions regarding whether a surgical procedure should be excluded from the Medicare ASC list of covered surgical procedures are based on assessments of the needs of Medicare beneficiaries and not all patient populations. We include on the ASC list all procedures we believe are appropriate for some Medicare beneficiaries in order to provide physicians and patients with the greatest possible choice for sites-of-service. We expect that physicians will consider for each individual patient which site-of-service is most appropriate. We understand that the procedures on the ASC list are sometimes more appropriately performed on an inpatient basis due to the individual's age or other clinical considerations.

Comment: Many commenters supported the addition of the procedures listed in Table 43 of the CY 2011 OPPS/ASC proposed rule to the list of ASC covered surgical procedures, including the procedures described by CPT codes 37205 and 37206. Commenters also requested that CMS add the procedures described by the 48 CPT codes displayed in Table 52 below to the list of ASC covered surgical procedures. Some commenters also requested that a total of 9 specific CPT unlisted codes be added to the ASC list, displayed in Table 53, below. The commenters argued that these procedures are less complex and/or as safe as procedures already paid for when performed in the ASC setting.

TABLE 52—SURGICAL PROCEDURES REQUESTED FOR ADDITION TO THE CY 2011 ASC LIST OF COVERED SURGICAL PROCEDURES

CY 2011 CPT code	CY 2011 long descriptor
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft.
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft.
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft.
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts).
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft).
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies).
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts).
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts).
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft.
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft).
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation.
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation.
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (e.g., for hemifacial microsomia).
21343	Open treatment of depressed frontal sinus fracture.
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation.
21365	Open treatment of complicated (e.g., comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches.
21385	Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operation).
21386	Open treatment of orbital floor blowout fracture; periorbital approach.
21387	Open treatment of orbital floor blowout fracture; combined approach.
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft).
21408	Open treatment of fracture of orbit, except blowout; with bone grafting (includes obtaining graft).
21422	Open treatment of palatal or maxillary fracture (LeFort I type);
21423	Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches.
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint.
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints.

TABLE 52—SURGICAL PROCEDURES REQUESTED FOR ADDITION TO THE CY 2011 ASC LIST OF COVERED SURGICAL PROCEDURES—Continued

CY 2011 CPT code	CY 2011 long descriptor
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2.
22851	Application of intervertebral biomechanical device(s) (e.g., synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure).
27415	Osteochondral allograft, knee, open.
29867	Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty).
30999	Unlisted procedure, nose.
31292	Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression.
31293	Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression.
54332	1-stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap.
54336	1-stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap.
54535	Orchiectomy, radical, for tumor; with abdominal exploration.
57310	Closure of urethrovaginal fistula;
60260	Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid.
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; cervical.
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, cervical.
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar.
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure).
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar.
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical.
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar.
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure).
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc).
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace.
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure).

TABLE 53—CPT UNLISTED CODES REQUESTED FOR ADDITION TO THE CY 2011 ASC LIST OF COVERED SURGICAL PROCEDURES

CY 2011 CPT code	CY 2011 long descriptor
21089	Unlisted maxillofacial prosthetic procedure.
21299	Unlisted craniofacial and maxillofacial procedure.
21499	Unlisted musculoskeletal procedure, head.
30999	Unlisted procedure, nose.
40799	Unlisted procedure, lips.
40899	Unlisted procedure, dentoalveolar structures.
41599	Unlisted procedure, tongue, floor of mouth.
41899	Unlisted procedure, dentoalveolar structures.
42299	Unlisted procedure, palate, uvula.

Response: We appreciate commenters' support of the proposed addition of the procedures listed in Table 43 of the CY 2011 OPPS/ASC proposed rule to the ASC list of covered surgical procedures for CY 2011. As stated above, we note that the descriptors for CPT codes 37205 and 37206 are significantly changing effective January 1, 2011, which required us to reevaluate their appropriateness in the ASC setting. Based on the review of our clinical staff, we determined that the level of care indicated by the new descriptors for CPT codes 37205 and 37206 make these codes ineligible for payment in the ASC setting. However, we will recognize as ASC covered surgical procedures two new CY 2011 CPT codes that, prior to January 1, 2011, would have been described in part under the CY 2010 CPT code descriptors for 37205 and 37206. Specifically, we believe that the procedures described by CPT codes 37221 and 37223 may be safely performed in the ASC setting, and that the addition of these procedures to the ASC list of covered surgical procedures in CY 2011 is consistent with our proposal to add CPT codes 37205 and 37206 to the ASC list of covered surgical procedures in CY 2011, because the CPT codes for 37221 and 37223 now describe services that would have been described by CPT codes 37205 and 37206 had the CPT Editorial Panel not changed the descriptors for these codes.

We reviewed all of the surgical procedures that commenters requested be added to the ASC list of covered surgical procedures, except the procedures that may be reported by the CPT unlisted codes listed in Table 53, above, because those codes are not eligible for addition to the ASC list, consistent with our final policy which is discussed in detail in the August 2, 2007 final rule (72 FR 42484 through

42486). We do not agree that most of the procedures recommended by the commenters are appropriate for provision to Medicare beneficiaries in ASCs. Although the commenters asserted that the procedures they were requesting for addition to the list are less complex than and as safe as procedures already on the list, our review did not support those assertions. We exclude from ASC payment any procedure for which standard medical practice dictates that the beneficiary who undergoes the procedure would typically be expected to require active medical monitoring and care at midnight following the procedure (overnight stay) as well as all surgical procedures that our medical advisors determine may be expected to pose a significant safety risk to Medicare beneficiaries when performed in an ASC. The criteria used under the revised ASC payment system to identify procedures that would be expected to pose a significant safety risk when performed in an ASC include, but are not limited to, those 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; or are designated as requiring inpatient care (§ 416.166). In our review of the procedures listed in Table 52, we determined that most of the procedures either would be expected to pose a significant risk to beneficiary safety or would be expected to require an overnight stay. Specifically, we found that prevailing medical practice called for inpatient hospital stays for beneficiaries undergoing many of the procedures and that some of the procedures directly involve major blood vessels and/or may result in extensive blood loss.

After consideration of the public comments we received, we are finalizing the addition of four of the six proposed procedures to the CY 2011 ASC list of covered surgical procedures. We are not finalizing the proposed addition of CPT codes 37205 and 37206. The CPT Editorial Panel changed the descriptors for these codes effective January 1, 2011. We reviewed these codes and, based on our review, determined that the level of care indicated by the new descriptors for these codes make these codes ineligible for payment in the ASC setting. However, we are adding procedures described by CPT codes 37221 and 37223 to the list of covered surgical procedures for CY 2011 because we believe that these procedures may be safely performed in the ASC setting and that the addition of these procedures is consistent with our proposal to add CPT codes 37205 and 37206 to the ASC list of covered surgical procedures in CY 2011, because the CPT codes for 37221 and 37223 now describe services that would have been described by CPT codes 37205 and 37206 had the CPT Editorial Panel not changed the descriptors for these codes. The six procedures that we are adding to the list of ASC covered surgical procedures for CY 2011, their descriptors, and payment indicators are displayed in Table 54 below.

TABLE 54—NEW ASC COVERED SURGICAL PROCEDURES FOR CY 2011

CY 2011 CPT/HCPCS code	CY 2011 long descriptor	CY 2011 ASC payment indicator
37204	Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck.	G2
37210	Uterine fibroid embolization (ufe, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the procedure.	G2
37221	Revascularization, iliac artery, unilateral, initial vessel; with transluminal stent placement(s)	G2
37223	Revascularization, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s). (List separately in addition to code for primary procedure).	G2
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy.	G2
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed).	G2

b. Covered Surgical Procedures Designated as Office-Based

(1) Background

In the August 2, 2007 ASC final rule, we finalized our policy to designate as "office-based" those procedures that are added to the ASC list of covered surgical procedures in CY 2008 or later years that we determine are performed predominantly (more than 50 percent of the time) in physicians' offices based on consideration of the most recent available volume and utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. In that rule, we also finalized our policy to exempt all procedures on the CY 2007 ASC list from application of the office-based classification (72 FR 42512). The procedures that were added to the ASC list of covered surgical procedures beginning in CY 2008 that we determined were office-based were identified in Addendum AA to that rule by payment indicator "P2" (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on OPPS relative payment weight); "P3" (Office-based surgical procedures added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on MPFS non-facility PE RVUs); or "R2" (Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS non-facility PE RVUs; payment based on OPPS relative payment weight), depending on whether we estimated it would be paid according to the standard ASC payment methodology based on its OPPS relative payment weight or at the MPFS non-facility PE RVU amount.

Consistent with our final policy to annually review and update the list of surgical procedures eligible for payment in ASCs, each year we identify surgical procedures as either temporarily or permanently office-based after taking into account updated volume and utilization data.

(2) Changes to Covered Surgical Procedures Designated as Office-Based for CY 2011

In developing the CY 2011 OPPS/ASC proposed rule (75 FR 46330), we followed our policy to annually review and update the surgical procedures for which ASC payment is made and to identify new procedures that may be appropriate for ASC payment, including their potential designation as office-based. We reviewed CY 2009 volume and utilization data and the clinical characteristics for all surgical procedures that are assigned payment indicator "G2" in CY 2010, as well as for those procedures assigned one of the temporary office-based payment indicators, specifically "P2*," "P3*," or "R2*" in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60605 through 60608). We also examined the data for the five procedures that we proposed to add to the ASC list of covered surgical procedures for CY 2011 (listed in Table 43 of the CY 2011 OPPS/ASC proposed rule (75 FR 46330)) to determine if these procedures should be designated as office-based.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46331), we indicated that our review of the CY 2009 volume and utilization data resulted in our identification of six surgical procedures that we believed met the criteria for designation as office-based. We stated that the data indicated that the procedures are performed more than 50 percent of the time in physicians' offices, and that our medical advisors believed the services are of a level of complexity consistent with other procedures performed routinely in physicians' offices. The six CPT codes we proposed to permanently designate as office-based were listed in Table 44 of the CY 2011 OPPS/ASC proposed rule (75 FR 46332) and include the following: 20697 (Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (e.g., spatial frame), including imaging; exchange (i.e., removal and replacement) of strut, each), 27767 (Closed treatment of posterior malleolus fracture; without manipulation), 37205, 37206, 37210, and 50593. Subsequent to the release of the CY 2011 OPPS/ASC proposed rule, we recognized that the long descriptors for CPT codes 50593 and 37210 in Table 44 were incorrect. We corrected Table 44 on the CMS Web site for the CY 2011 OPPS/ASC proposed rule at *http://www.cms.gov/ASCPayment/.* We noted in the proposed rule that four of these six procedures are procedures that we also proposed to add to the ASC list of covered surgical procedures for CY 2011: CPT codes 37205, 37206, 37210, and 50593. The other two procedures, described by CPT codes 20697 and 27767, are already on the ASC list of covered surgical procedures.

Comment: Some commenters expressed their continued disagreement with the policy to make payment at the lower of the ASC rate or MPFS nonfacility PE RVU payment amount for procedures we identify as office-based and requested that CMS not finalize any of the proposed office-based designations. They believed that, due to the payment limits required by CMS' payment policy for providing these services in ASCs, beneficiaries who require the level of care provided in ASCs instead have to receive treatment in the more costly HOPD setting. They pointed out that even when a procedure is frequently performed in an office, there are circumstances when the office is an inappropriate or unavailable setting, and that the site-of-service criterion fails to recognize the variation in practice patterns across the country. The commenters also stated that the continuation of this policy expands the gap between the rates that ASCs should receive based upon the OPPS APC relative weights and the actual payment they receive based on the revised ASC payment system policies.

The commenters recommended that CMS establish a minimum volume threshold before designating a procedure office-based in order to ensure that the data used to apply this policy are reliable. They asserted that unless CMS includes multiple years of data in its calculation, services with low volume can reach the 50 percent threshold with little change in the distribution of procedures across sites of care. They also recommended that CMS raise the utilization threshold above 50 percent for designating a procedure as office-based and only use current data to make the office-based assessment.

Response: As we have stated in the past (74 FR 60605 through 60606), we continue to believe that our policy of identifying low complexity procedures that are performed predominantly in physicians' offices and limiting their payment in ASCs to the physician's office payment amount is necessary and valid. We believe this is the most appropriate approach to preventing the creation of payment incentives for services to move from physicians' offices to ASCs for the many newly covered low complexity procedures on the ASC list. We do not agree with the commenter that this policy creates incentives for patients to be treated in the HOPD, because we believe that paying for these services that are typically performed in a physician office at the lower of the ASC or the MPFS nonfacility PE RVU payment amount is appropriate and adequate to ensure beneficiary access in the ASC setting. We continue to believe that it is appropriate that ASCs be paid no more for performing office-based procedures than those procedures would be paid when performed in physicians' offices, in order to deter inappropriate migration of these surgical procedures to ASCs based on financial considerations rather than clinical needs. Although our policy to pay for some services at the MPFS non-facility PE RVU amount does introduce payment for a number of procedures at rates not based on the ASC relative payment weights and, as such, may be viewed as expanding the gap between the rates that ASCs should receive based upon the OPPS APC relative weights and the actual payment they receive based on the revised ASC payment system policies between the OPPS and ASC payment system, we do not believe that the alternative of making payments at the higher ASC rate is preferable. None of the office-based procedures was eligible for ASC payment prior to implementation of the revised payment system and we see no inherent unfairness in limiting ASC payment to the rate for the lower-intensity site-of-service (physician's office) that our data indicate is the care setting for most Medicare cases. We expect physicians in all cases to choose a care setting that is appropriate for the individual patient.

We do not agree with the commenters who asserted that we should alter our established office-based payment methodology to establish a minimum volume threshold or include multiple years of data. As we have stated in the past (74 FR 60605 through 60606), we are confident that the CY 2009 claims data, the most recent full year of volume and utilization data, are an appropriate source to inform our decisions regarding the site-of-service for procedures. Because this is national data, it also reflects variation in practice patterns across the Nation. In our review process, when we believe that the available data are inadequate bases upon which to make a determination that a procedure should be office-based, we either make no change to the procedure's payment status or make the change temporary and reevaluate our decision using data that become available for our next evaluation. We believe that it is appropriate to continue using our judgment regarding whether the volume

of cases and the proportion of cases that are provided in the physicians' office setting indicate that the procedure is an office-based procedure in addition to our medical advisors' clinical judgments, utilization data for procedures that are closely related to the procedures being evaluated, and any other information that is available to us. Thus, we will continue to use our existing review and decision processes.

Comment: Several commenters specifically addressed our proposals to designate the procedures listed in Table 44 of the CY 2011 OPPS/ASC proposed rule as office-based, and argued that the procedures described by the following CPT codes are not performed more than 50 percent of the time in a physician's office: 37205, 37206, 37210, and 50593.

Response: We appreciate commenters' assessment of the specific CPT codes we proposed to newly designate as office-based for CY 2011. We reviewed the most current utilization data and agree that the procedures described by CPT codes 37205, 37206, 37210, and 50593 are not performed more than 50 percent of the time in a physician's office. Therefore, we are not designating these CPT codes as office-based procedures for CY 2011 as we proposed. We also note that, as stated previously, the descriptors for CPT codes 37205 and 37206 are significantly changing for CY 2011 and will not be added to the ASC list of covered surgical procedures.

The utilization data for the other procedures listed in Table 44 of the proposed rule, described by CPT codes 20697 and 27767, continue to indicate that these procedures are performed more than 50 percent of the time in physicians' offices and did not change between the proposed rule and this final rule with comment period. Therefore, we continue to believe it is appropriate to designate these CPT codes as office-based for CY 2011.

After consideration of the public comments we received, we are finalizing our CY 2011 proposals, with modification, to designate the procedures displayed in Table 55 below as office-based for CY 2011. We also examined the clinical characteristics and utilization data for procedures related to the two new CY 2011 CPT codes we are adding to the ASC list of covered surgical procedures, CPT codes 37221 and 37223, as discussed in section XV.C. of this final rule with comment period, and we determined that these codes should not be designated as office-based for CY 2011.

TABLE 55—CY 2011 FINAL DESIGNATIONS OF ASC COVERED SURGICAL PROCEDURES NEWLY DESIGNATED AS PERMANENTLY OFFICE-BASED

CY 2011 CPT code	CY 2010 long descriptor	CY 2010 ASC payment indicator	Proposed CY 2011 ASC payment indicator*	Final CY 2011 ASC payment indicator
20697	Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (e.g., spatial frame), including imaging; exchange (i.e., removal and replacement of strut, each).	G2	P2	P2
27767	Closed treatment of posterior malleolus fracture; without manipulation	G2	P2	P2

*Payment indicators are based on a comparison of the rates according to the ASC standard ratesetting methodology and the MPFS rates. At the time this final rule with comment period is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this final rule with comment period reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the January 2011 payment rate files issued to contractors and posted to the ASC Web site at *http://www.cms.gov/ASCPayment/.*

We also reviewed CY 2009 volume and utilization data and other information for the six procedures proposed for temporary office-based status in the CY 2010 OPPS/ASC proposed rule (74 FR 35382) and finalized for temporary office-based status in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60607). Among these six procedures, there were almost no claims data for three procedures: CPT code 0099T (Implantation of intrastromal corneal ring segments); CPT code 0124T (Conjunctival drug placement); and CPT code 67229 (Treatment of extensive or progressive retinopathy, one or more sessions; preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (e.g., retinopathy of prematurity), photocoagulation or cryotherapy). Consequently, we proposed to maintain their temporary office-based designations for CY 2011. We also proposed to maintain in CY 2011 the temporary office-based designation for the four codes that became effective in the July 2010 ASC quarterly update: CPT code 0226T (Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed); CPT code 0227T (Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)); CPT code 0232T (Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed); and HCPCS code C9800 (Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies), because no data were available for these codes at the time of the proposed rule.

As a result of our review of the remaining three procedures that have temporary office-based designations for CY 2010 for which we do have claims data, we proposed to make permanent the office-based designations for all of them for CY 2011. The three surgical procedure codes are: CPT code 46930 (Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)); CPT code 64455 (Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton's neuroma)); and CPT code 64632 (Destruction by neurolytic agent; plantar common digital nerve). We stated in the CY 2011 OPPS/ASC proposed rule (75 FR 46333) that the volume and utilization data for these CPT codes are sufficient to support our determination that these procedures are performed predominantly in physicians' offices. Therefore, we proposed to make permanent the office-based designations for the three procedures for CY 2011.

The procedures that we proposed to permanently designate as office-based for CY 2011 that were temporarily designated as office-based procedures in CY 2010 were displayed in Table 45 of the CY 2011 OPPS/ASC proposed rule

(75 FR 46334). The procedures that we proposed to temporarily designate as office-based for CY 2011 were displayed in Table 46 of the CY 2011 OPPS/ASC proposed rule (75 FR 4635). The procedures for which the proposed office-based designation for CY 2011 is temporary also were indicated by an asterisk in Addendum AA to the proposed rule.

We did not receive any public comments that addressed our proposals to designate the three procedures listed in Table 45 of the CY 2011 OPPS/ASC proposed rule (75 FR 46334), and restated in Table 56, below, as permanently office-based for CY 2011. Therefore, we are finalizing our proposal to designate the three procedures listed in Table 45 of the CY 2011 OPPS/ASC proposed rule, which were designated as temporarily office-based for CY 2010, as permanently office-based for CY 2011. We list the codes, long descriptors, CY 2010 ASC payment indicators, and CY 2011 ASC payment indicators for these three procedures in Table 56 below. We also did not receive any public comments on our proposal to temporarily designate as office-based for CY 2011 the seven procedures listed in Table 46 of the CY 2011 OPPS/ASC proposed rule (75 FR 46335) and restated in Table 57, below. We are finalizing our proposal to designate the seven procedures listed in Table 46 of the CY 2011 OPPS/ASC proposed rule, which were designated as temporarily office-based for CY 2010, as temporarily office-based for CY 2011. We list the codes, long descriptors, CY 2010 ASC payment indicators, and CY 2011 ASC payment indicators for these seven procedures in Table 57 below.

TABLE 56—CY 2010 TEMPORARILY DESIGNATED OFFICE-BASED ASC COVERED SURGICAL PROCEDURES THAT ARE DESIGNATED AS PERMANENTLY OFFICE-BASED FOR CY 2011

CY 2011 CPT code	CY 2011 long descriptor	CY 2010 ASC payment indicator	Final CY 2011 ASC payment indicator **
46930	Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency).	P3 *	P3
64455	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton's neuroma).	P3 *	P3
64632	Destruction by neurolytic agent; plantar common digital nerve	P3 *	P3

* If designation is temporary.

** Payment indicators are based on a comparison of the rates according to the ASC standard ratesetting methodology and the MPFS rates. At the time this final rule with comment period is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this final rule with comment period reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the January 2011 payment rate files issued to contractors and posted to the ASC Web site at *http://www.cms.gov/ASCPayment/.*

TABLE 57—CY 2010 TEMPORARILY DESIGNATED OFFICE–BASED ASC COVERED SURGICAL PROCEDURES THAT ARE DESIGNATED AS TEMPORARILY OFFICE–BASED FOR CY 2011

CY 2011 HCPCS code	CY 2011 long descriptor	CY 2010 ASC payment indicator	Final CY 2011 ASC payment indicator**
0099T	Implantation of intrastromal corneal ring segments	R2*	R2*
0124T	Conjunctival incision with posterior extrascleral placement of pharmacological agent (does not include supply of medication).	R2*	R2*
0226T	Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed.	R2*	R2*
0227T	Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies).	R2*	R2*
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed.	R2*	R2*
67229	Treatment of extensive or progressive retinopathy, one or more sessions; preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (e.g., retinopathy of prematurity), photocoagulation or cryotherapy.	R2*	R2*
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies.	R2*	R2*

* If designation is temporary.

**Payment indicators are based on a comparison of the rates according to the ASC standard ratesetting methodology and the MPFS rates. At the time this final rule with comment period is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this final rule with comment period reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the January 2011 payment rate files issued to contractors and posted to the ASC Web site at *http://www.cms.gov/ASCPayment/.*

Displayed in Table 47 of the CY 2011 OPPS/ASC proposed rule (75 FR 46337) were new (or substantially revised) CY 2010 CPT codes to which we assigned temporary office-based payment indicators in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60608). As explained in section XV.B.1. of that final rule with comment period (74 FR 60599 and 60607), we reviewed all of the newly created HCPCS codes that became available after the issuance of the CY 2009 OPPS/ASC proposed rule that are used to report surgical procedures in CY 2010 to evaluate their appropriateness for the ASC list of covered surgical procedures. Of the procedures reported by new or substantially revised CY 2010 CPT codes that we determined should not be excluded from the ASC list based on our clinical review, including assessment of available utilization and volume data for any closely related procedures and consideration of other available information, we determined that 16 of the procedures would predominantly be performed in physicians' offices. However, because we had no utilization data for the procedures specifically described by these new CPT codes, we made the office-based designations temporary rather than permanent and stated that we would reevaluate the procedures when data become available (74 FR 60607 through 60608). The temporary payment indicators for the 16 office-based procedures displayed in Table 47 were interim designations and were open to public comment during the 60-day comment period following the release of the CY 2010 OPPS/ASC final rule with comment period. We indicated that we would respond to public comments received during that 60-day comment period as well as the comment period following the CY 2011 OPPS/ASC proposed rule in this CY 2011 OPPS/ASC final rule with comment period.

Comment: Some commenters to the CY 2010 OPPS/ASC final rule with comment period and the CY 2011 OPPS/ASC proposed rule disagreed with the designation of CPT code 21015 (Radical resection of tumor (e.g., malignant neoplasm, soft tissue of the face or scalp; less than 2 cm) as temporarily office-based. According to the commenters, Medicare claims data indicate that this procedure is not performed in the physician office setting more than 50 percent of the time.

Response: We disagree with the commenters' assertion that CPT code 21015 should not be temporarily office-based. We also do not agree with the commenters that we can use the Medicare claims data to assess whether the procedure described by CPT code 21015 is predominantly performed in the office or non-office setting. As we explained in the CY 2010 OPPS/ASC final rule with comment period and in the CY 2011 OPPS/ASC proposed rule (74 FR 60599, 60607, and 60608 and 75 FR 46337), the CPT code descriptor for CPT code 21015 was one of several HCPCS codes with descriptors that were so substantially revised for CY 2010 that we consider them to be new for CY 2010. Therefore, the most current available Medicare claims data from 2009 does not reflect the procedure now described by CPT code 21015 and should not be used to determine site-of-service. Our medical review team reviewed the clinical characteristics of this procedure and the utilization data for related procedures, and we continue to believe that it would predominantly be performed in the physician office. Therefore, we are maintaining its designation as temporarily office-based in CY 2011.

After consideration of the public comments we received, we are finalizing our CY 2011 proposal, without modification, to maintain the temporary office-based payment indicators for the new CY 2010 CPT codes as displayed in Table 58 below.

TABLE 58—FINAL CY 2011 PAYMENT INDICATORS FOR NEW CY 2010 CPT CODES FOR ASC COVERED SURGICAL PROCEDURES DESIGNATED AS TEMPORARILY OFFICE–BASED ON AN INTERIM BASIS IN THE CY 2010 OPPS/ASC FINAL RULE WITH COMMENT PERIOD

CY 2011 CPT code	CY 2011 long descriptor	CY 2010 ASC payment indicator	Final CY 2011 ASC payment indicator**
21015	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of face or scalp; less than 2 cm).	R2*	R2*
21555	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm.	P3*	P3*
21930	Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm.	P3*	P3*
23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm.	P3*	P3*
24075	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm.	P3*	P3*
25075	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm.	P3*	P3*
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm.	P3*	P3*
27047	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm.	P3*	P3*
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm.	P3*	P3*
27618	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm.	P3*	P3*
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater.	P3*	P3**
28041	Excision, tumor, soft tissue of foot or toe, subfascial (e.g., intramuscular); 1.5 cm or greater.	R2*	R2*
28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm.	P3*	P3*
28045	Excision, tumor, soft tissue of foot or toe, subfascial (e.g., intramuscular); less than 1.5 cm.	P3*	P3*

TABLE 58—FINAL CY 2011 PAYMENT INDICATORS FOR NEW CY 2010 CPT CODES FOR ASC COVERED SURGICAL PROCEDURES DESIGNATED AS TEMPORARILY OFFICE–BASED ON AN INTERIM BASIS IN THE CY 2010 OPPS/ASC FINAL RULE WITH COMMENT PERIOD—Continued

CY 2011 CPT code	CY 2011 long descriptor	CY 2010 ASC payment indicator	Final CY 2011 ASC payment indicator**
28046	Radical resection of tumor (e.g., malignant neoplasm), soft tissue of foot or toe; less than 3 cm.	R2*	R2*
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg.	R2*	R2*

* If designation is temporary.

**Payment indicators are based on a comparison of the rates according to the ASC standard ratesetting methodology and the MPFS rates. At the time this final rule with comment period is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this final rule with comment period reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the January 2011 payment rate files issued to contractors and posted to the ASC Web site at *http://www.cms.gov/ASCPayment/*.

In addition to the comments we received on the office-based designations of procedures specifically discussed in the CY 2011 OPPS/ASC proposed rule, we received the following comments on the proposed office-based status of procedures as listed in Addendum AA of the proposed rule.

Comment: One commenter requested that CMS not consider as office-based CPT codes 21011 (Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm), 21012 (Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater), 21013 (Excision, tumor, soft tissue of face and scalp, subfascial (e.g., subgaleal, intramuscular); less than 2 cm), 21014 (Excision, tumor, soft tissue of face and scalp, subfascial (e.g., subgaleal, intramuscular); 2 cm or greater), and 21016 (Radical resection of tumor (e.g., malignant neoplasm), soft tissue of face or scalp; 2 cm or greater) until there are significant data to show that these codes are performed over 50 percent of the time in physicians' offices.

Response: Because CPT codes 21011, 21012, 21013, 21014, and 21016 are new for CY 2010, we have no claims data showing in which setting these codes are performed the majority of the time. As is our standard process, we examined the available utilization and volume data for closely related procedures and considered other relevant clinical information to determine whether these procedures should be considered office-based. We continue to believe that the procedures described by CPT codes 21011, 21012, 21013, and 21014 would be performed predominantly in the physician office-setting and are therefore maintaining the office-based designations for these procedures in CY 2011 as proposed. We note that we did not propose, nor are we finalizing, an office-based designation for the procedure described by CPT code 21016.

Comment: Several commenters disagreed with the proposed assignment of payment indicator "P2" to CPT codes 37765 (Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions stab phlebectomy of varicose veins, 1 extremity; 10–20 stab incisions) and 37766 (Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions). According to the commenters, the CY 2011 MPFS proposed rule included nonfacility payment for these two procedures, but they requested that we postpone changing the payment indicator for CPT codes 37765 and 37766 from "R2" to "P3" for one year and continue to base payment on the OPPS rather than the MPFS despite the availability of MPFS non-facility PE RVUs for these procedures.

Response: We do not agree with the commenter that it would be appropriate to maintain payment indicator "R2" for the office-based procedures described by CPT codes 37765 and 37766 for CY 2011. As the commenter notes, there are now non-facility PE RVUs upon which to base payment for these procedures, and we only assign payment indicator "R2" to those office-based surgical procedures added to the ASC list in CY 2008 or later without MPFS non-facility PE RVUs. Therefore, we are finalizing our proposal to assign payment indicator P3 to CPT codes 37765 and 37766 for CY 2011.

c. ASC Covered Surgical Procedures Designated as Device-Intensive

(1) Background

As discussed in the August 2, 2007 final rule (72 FR 42503 through 42508), we adopted a modified payment methodology for calculating the ASC payment rates for covered surgical procedures that are assigned to the subset of OPPS device-dependent APCs with a device offset percentage greater than 50 percent of the APC cost under the OPPS, in order to ensure that payment for the procedure is adequate to provide packaged payment for the high-cost implantable devices used in those procedures. We assigned payment indicators "H8" (Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate) and "J8" (Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate) to identify the procedures that were eligible for ASC payment calculated according to the modified methodology, depending on whether the procedure was included on the ASC list of covered surgical procedures prior to CY 2008 and, therefore, subject to transitional payment as discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68739 through 68742). The device-intensive procedures for which the modified rate calculation methodology applies in CY 2010 were displayed in Table 68 and in Addendum AA to the CY 2010 OPPS/ASC final rule with comment period (74 FR 60610 through 60611, and 60692 through 60752).

(2) Changes to List of Covered Surgical Procedures Designated as Device Intensive for CY 2011

In the CY 2011 OPPS/ASC proposed rule (75 FR 46338 through 46341), we proposed to update the ASC list of covered surgical procedures that are eligible for payment according to the device-intensive procedure payment methodology for CY 2011, consistent with the proposed OPPS device-dependent APC update, reflecting the proposed APC assignments of procedures, designation of APCs as device-dependent, and APC device offset percentages based on the CY 2009 OPPS claims and cost report data

available for the proposed rule. The OPPS device-dependent APCs were discussed further in section II.A.2.d.(1) of the proposed rule. The ASC covered surgical procedures that we proposed to designate as device-intensive and that would be subject to the device-intensive procedure payment methodology for CY 2011 were listed in Table 48 in the CY 2011 OPPS/ASC proposed rule (75 FR 46339 through 46341).

Comment: Some commenters expressed general concerns regarding the sufficiency of ASC payment for device-related services and recommended modifications to the ASC device-intensive payment methodology. First, the commenters argued that CMS should not adjust the device-related portion of the ASC payment for device-intensive procedures by the wage index. According to the commenters, the acquisition of devices occurs on a national market, and the price is the same regardless of the location of the ASC. Second, the commenters argued that CMS should not apply the ASC conversion factor to the device-related portion of the payment for all procedures for which CMS can establish a median device cost, regardless of whether they meet the criteria to be designated as device-intensive under the established methodology. The commenters stated that, unlike ASCs' general abilities to achieve greater operational efficiencies than HOPDs, ASCs are unable to extract greater discounts on devices and expensive operative supplies than their hospital counterparts.

Response: In the August 2, 2007 final rule (72 FR 42508), we established that the modified payment methodology for calculating ASC payment rates for device-intensive procedures shall 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 (that is, the device offset percentage is greater than 50). We continue to believe these criteria ensure that ASC payment rates are adequate to provide packaged payment for high cost implantable devices and ensure Medicare beneficiaries have access to these procedures in all appropriate settings of care. As we have stated in the past (74 FR 60609), we do not agree that we should change our criteria and treat as device-intensive those services that are assigned to APCs for which the device offset percentage is less than 50 percent or ASC services that are not assigned to device-dependent APCs. Under the modified payment methodology for ASC covered surgical procedures designated as device-intensive, we separately determine both the device payment and service payment portions of the ASC payment rate, and apply the ASC conversion factor only to the specifically 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. The 50-percent device offset threshold is established to ensure that the ASC conversion factor is not applied to the costs of high cost implantable devices, which likely do not vary between ASCs and HOPDs in the same manner service costs have been shown to vary. As we have stated in the past (73 FR 68734 and 74 FR 60609), we continue to believe that when device costs comprise less than 50 percent of total procedure costs, those costs are less likely to be as predictable across sites-of-service. Accordingly, we believe that it is possible for ASCs to achieve efficiencies relative to HOPDs when providing those procedures, and that the application of the ASC conversion factor to the entire ASC payment weight is appropriate.

We also continue to believe it would not be appropriate to vary the percentage of the national payment that is wage adjusted for different services such as applying the wage index only to the service portion of the ASC payment for device-intensive procedures as the commenters request. Under the revised ASC payment system, we utilize 50 percent as the labor-related share to adjust national ASC payment rates for geographic wage differences. We apply to ASC payments the IPPS pre-floor, pre-reclassification wage index values associated with the June 2003 OMB geographic localities, as recognized under the IPPS and OPPS, in order to adjust the labor-related portion of the national ASC payment rates for geographic wage differences. Consistent with the OPPS, we apply the ASC geographic wage adjustment to the entire ASC payment rate for device-intensive procedures. As we have noted in the past (73 FR 68735 and 74 FR 60609), MedPAC has indicated its intent to evaluate our method for adjusting payments for variations in labor costs in light of differences in labor-related costs for device-implantation services. We look forward to reviewing the results of its evaluation, as well as any recommendations it may provide, regarding the OPPS or ASC wage adjustment policy.

Comment: One commenter requested that CMS adjust the OPPS device offset percentages for ASC device-intensive payment purposes to account for the effects of charge compression, specifically for APCs 0385 and 0386. The commenter suggested that CMS "decompress" the supply median costs to minimize any artificial reductions that charge compression causes in the estimate of the OPPS device offset percentages.

Response: Charge compression is the practice of applying a lower charge markup to higher-cost services and a higher charge markup to lower-cost services. As a result of charge compression, the cost-based OPPS weights incorporate aggregation bias, undervaluing high cost items and overvaluing low cost items when an estimate of average markup, embodied in a single CCR, is applied to items of widely varying costs in the same cost center. As discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68524), we did not adopt any short-term statistical regression based adjustments under the OPPS that would serve to "decompress" the median costs for procedures involving devices, or for any other procedures. Rather, we chose to focus on long-term changes to Medicare cost reporting to address the effects of charge compression, including the creation of two new cost centers, "Medical Supplies Charged to Patients" and "Implantable Devices Charged to Patients," as discussed in more detail in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60342 through 60346). As we stated in that final rule with comment period, we believe that this change to how hospitals report costs for devices and supplies will improve our future estimates of costs related to high cost implantable devices, including the device offset percentages upon which we base the device portions of ASC payment rates for device-intensive procedures (74 FR 60609).

Comment: Several commenters remarked on the adequacy of the proposed payment rates calculated according to the ASC device-intensive payment methodology for procedures involving auditory osseointegrated devices, described by CPT codes 69714 (Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy); 69715 (Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy); 69717 (Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator;

without mastoidectomy); and 69718 (Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy). The commenters expressed appreciation for the proposed increase in payment for these procedures but indicated that the proposed payment rates remain insufficient for covering ASCs' costs for providing the procedures and requested that CMS further increase these rates for CY 2011. They believed that the rates might have a negative impact on the availability of these services in an ASC setting and therefore might limit patient access. Other commenters stated that paying ASCs a higher rate than hospital outpatient departments would encourage movement of the procedures to the "more economical" ASC environment.

Response: We appreciate commenters' support of the proposed payment rates for procedures involving auditory osseointegrated devices, but we disagree with the commenters' assertion that we should increase payment rates for these procedures further in order to maintain beneficiary access. We believe that the final CY 2011 ASC payment rates for these procedures, calculated according to the ASC device-intensive ratesetting methodology, are appropriate and adequate to ensure beneficiaries have access to these procedures in the ASC setting.

Comment: Some commenters asked that CMS add to the ASC list of device-intensive procedures those procedures that require items that would have been separately payable under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule prior to the implementation of the revised ASC payment system on January 1, 2008. These commenters requested that specific procedures that were not included in Table 48 of the CY 2011 OPPS/ASC proposed rule be recognized as device-intensive for CY 2011, specifically those procedures involving CPT codes 19325 (Mammaplasty, augmentation; with prosthetic implant), 19340 (Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction), and 19357 (Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion). The commenters argued that the device costs are inadequately covered in an ASC setting now that ASCs are no longer paid separately under the DMEPOS fee schedule for the breast prostheses used in these procedures.

Response: We appreciate commenters' recommendations on how we should designate procedures as device-intensive under the revised ASC payment system. In the August 2, 2007 revised ASC payment system final rule (72 FR 42508), we established that the modified payment methodology for calculating ASC payment rates for device-intensive procedures shall 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 (that is, the device offset percentage is greater than 50). We believe these criteria ensure that ASC payment rates are adequate to provide packaged payment for high cost implantable devices and ensure beneficiaries have access to these procedures in all appropriate care settings. The procedure described by CPT code 19340 is not assigned to a device-dependent APC under the OPPS, and while the procedures described by CPT codes 19325 and 19357 are assigned to a device-dependent APC under the OPPS (APC 0648 (Level IV Breast Surgery)), the device offset percentage for this APC is less than 50 percent. Therefore, none of these procedures qualify as being recognized as device-intensive for ASC payment purposes.

We do not agree that we should change our criteria and treat as device-intensive all ASC services that map to OPPS device-dependent APCs, or the subset of procedures that are assigned to OPPS device-dependent APCs with device offset percentages less than 50 percent, regardless of whether those procedures require items that would have been separately payable under the DMEPOS fee schedule prior to the implementation of the revised ASC payment system on January 1, 2008. We continue to believe that our current criteria ensure that ASC payment rates are adequate to provide packaged payment for high cost implantable devices and ensure Medicare beneficiaries have access to these procedures in all appropriate settings of care.

After consideration of the public comments we received, we are designating the ASC covered surgical procedures displayed in Table 59 below as device-intensive for CY 2011. The CPT code, the CPT code short descriptor, the CY 2011 ASC payment indicator, the CY 2011 OPPS APC assignment, the OPPS APC Title, and the CY 2011 OPPS APC device offset percentage are listed in Table 59. Each device-intensive procedure is assigned payment indicator "H8" or "J8," depending on whether it was subject to transitional payment prior to CY 2011. All of these procedures are included in Addendum AA to this final rule with comment period. The OPPS device-dependent APCs are discussed further in section II.A.2.d.(1) of this final rule with comment period. We note that, as discussed in section II.A.2.d.9. of this final rule with comment period, CPT code 64573 (incision for implantation of neurostimulator electrodes; cranial nerve), which we had proposed to continue to recognize as device-intensive for ASC payment purposes in CY 2011, is being deleted effective January 1, 2011, and is being replaced by CPT code 64568 (Incision for implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator). As we discuss in that section, we are deleting APC 0225 (Implantation of Neurostimulator Electrodes, Cranial Nerve), the APC to which CPT code 64573 was the only code assigned in CY 2010, and creating new APC 0318 (Implantation of Cranial Neurostimulator Pulse Generator and Electrode) to which CPT code 64568 will be assigned. Because CPT code 64568 is replacing CPT code 64573, we are recognizing CPT code 64568 as device-intensive for ASC payment purposes for CY 2011. These CPT and APC changes are reflected in Table 59, below.

TABLE 59—ASC COVERED SURGICAL PROCEDURES DESIGNATED AS DEVICE–INTENSIVE FOR CY 2011

CY 2011 CPT code	CY 2011 short descriptor	Final CY 2011 ASC payment indicator	Final CY 2011 OPPS APC	OPPS APC title	Final CY 2011 device-dependent APC offset percentage
24361	Reconstruct elbow joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59
24363	Replace elbow joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59
24366	Reconstruct head of radius.	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59
25441	Reconstruct wrist joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59
25442	Reconstruct wrist joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59
25446	Wrist replacement	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59
27446	Revision of knee joint	J8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59
33206	Insertion of heart pacemaker.	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	71
33207	Insertion of heart pacemaker.	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	71
33208	Insertion of heart pacemaker.	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	74
33212	Insertion of pulse generator.	H8	0090	Insertion/Replacement of Pacemaker Pulse Generator.	73
33213	Insertion of pulse generator.	H8	0654	Insertion/Replacement of a permanent dual chamber pacemaker.	74
33214	Upgrade of pacemaker system.	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	74
33224	Insert pacing lead & connect.	J8	0418	Insertion of Left Ventricular Pacing Elect	73
33225	Lventric pacing lead add-on.	J8	0418	Insertion of Left Ventricular Pacing Elect	73
33240	Insert pulse generator	J8	0107	Insertion of Cardioverter-Defibrillator	88
33249	Eltrd/insert pace-defib	J8	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	87
33282	Implant pat-active ht record.	J8	0680	Insertion of Patient Activated Event Recorders	71
53440	Male sling procedure	H8	0385	Level I Prosthetic Urological Procedures	61
53444	Insert tandem cuff	H8	0385	Level I Prosthetic Urological Procedures	61
53445	Insert uro/ves nck sphincter.	H8	0386	Level II Prosthetic Urological Procedures	71
53447	Remove/replace ur sphincter.	H8	0386	Level II Prosthetic Urological Procedures	71
54400	Insert semi-rigid prosthesis.	H8	0385	Level I Prosthetic Urological Procedures	61
54401	Insert self-contd prosthesis.	H8	0386	Level II Prosthetic Urological Procedures	71
54405	Insert multi-comp penis pros.	H8	0386	Level II Prosthetic Urological Procedures	71
54410	Remove/replace penis prosth.	H8	0386	Level II Prosthetic Urological Procedures	71
54416	Remv/repl penis contain pros.	H8	0386	Level II Prosthetic Urological Procedures	71
55873	Cryoablate prostate	H8	0674	Prostate Cryoablation	58
61885	Insrt/redo neurostim 1 array.	H8	0039	Level I Implantation of Neurostimulator Generator	86
61886	Implant neurostim arrays	H8	0315	Level II Implantation of Neurostimulator Generator	88
62361	Implant spine infusion pump.	H8	0227	Implantation of Drug Infusion Device	81
62362	Implant spine infusion pump.	H8	0227	Implantation of Drug Infusion Device	81
63650	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes.	58
63655	Implant neuroelectrodes	J8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	64
63685	Insrt/redo spine n generator.	H8	0039	Level I Implantation of Neurostimulator Generator	86
64553	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes.	58

TABLE 59—ASC COVERED SURGICAL PROCEDURES DESIGNATED AS DEVICE–INTENSIVE FOR CY 2011—Continued

CY 2011 CPT code	CY 2011 short descriptor	Final CY 2011 ASC payment indicator	Final CY 2011 OPPS APC	OPPS APC title	Final CY 2011 device-dependent APC offset percentage
64555	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes.	58
64560	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes.	58
64561	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes.	58
64565	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes.	58
64568	Implant neuroelectrodes	J8	0318	Implantation of Neurostimulator Electrodes, Cranial Nerve.	85
64575	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	64
64577	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	64
64580	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	64
64581	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	64
64590	Insrt/redo pn/gastr stimul	H8	0039	Level I Implantation of Neurostimulator Generator	86
65770	Revise cornea with implant.	H8	0293	Level VI Anterior Segment Eye Procedures	56
69714	Implant temple bone w/ stimul.	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59
69715	Temple bne implnt w/ stimulat.	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59
69717	Temple bone implant revision.	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59
69718	Revise temple bone implant.	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59
69930	Implant cochlear device	H8	0259	Level VII ENT Procedures	85

d. ASC Treatment of Surgical Procedures Removed From the OPPS Inpatient List for CY 2011

As we discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68724), we adopted a policy to include in our annual evaluation procedures proposed for removal from the OPPS inpatient list for possible inclusion on the ASC list of covered surgical procedures. For the CY 2011 OPPS/ASC proposed rule, we evaluated each of the three procedures we proposed to remove from the OPPS inpatient list for CY 2011 according to the criteria for exclusion from the list of covered ASC surgical procedures (75 FR 46341). We stated in the CY 2011 OPPS/ASC proposed rule (75 FR 46341) that we believe that all of these procedures should continue to be excluded from the ASC list of covered surgical procedures for CY 2011 because they would be expected to pose a significant risk to beneficiary safety or to require an overnight stay in ASCs. A full discussion about the APC Panel's recommendations regarding the procedures we proposed to remove from the OPPS inpatient list for CY 2011 may be found in section XI.B. of the CY 2011 OPPS/ASC proposed rule (75 FR 46301 through 46302). The HCPCS codes for these three procedures and their long descriptors were listed in Table 49 of the CY 2011 OPPS/ASC proposed rule (75 FR 46342).

Comment: One commenter requested that we add CPT codes 21193 (reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft) and 21395 (reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation) to the ASC covered surgical procedure list.

Response: We do not agree with the commenter that we should add CPT codes 21193 and 21395 to the ASC list of covered surgical procedures. We continue to believe that these procedures should be excluded from the ASC list of covered surgical procedures for CY 2011 because they would be expected to pose a significant risk to beneficiary safety or to require an overnight stay in ASCs.

After consideration of the public comment we received, we are finalizing our proposal, without modification, to continue to exclude the procedures described by the CPT codes listed in Table 49 of the CY 2011 OPPS/ASC proposed rule, and restated in Table 60 below, from the ASC list of covered surgical procedures.

TABLE 60—PROCEDURES EXCLUDED FROM THE ASC LIST OF COVERED PROCEDURES FOR CY 2011 THAT WERE REMOVED FROM THE CY 2011 OPPS INPATIENT LIST

CY 2011 CPT code	CY 2011 long descriptor
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft.
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft).

TABLE 60—PROCEDURES EXCLUDED FROM THE ASC LIST OF COVERED PROCEDURES FOR CY 2011 THAT WERE REMOVED FROM THE CY 2011 OPPS INPATIENT LIST—Continued

CY 2011 CPT code	CY 2011 long descriptor
25909	Amputation, forearm, through radius and ulna; re-amputation.

2. Covered Ancillary Services

Consistent with the established ASC payment system policy, in the CY 2011 OPPS/ASC proposed rule (75 FR 46342), we proposed to update the ASC list of covered ancillary services to reflect the proposed payment status for the services under the CY 2011 OPPS. Maintaining consistency with the OPPS may result in proposed changes to ASC payment indicators for some covered ancillary items and services because of changes that are being proposed under the OPPS for CY 2011. For example, a covered ancillary service that was separately paid under the revised ASC payment system in CY 2010 may be proposed for packaged status under the CY 2011 OPPS and, therefore, also under the ASC payment system for CY 2011. Comment indicator "CH," discussed in section XV.F. of the CY 2011 OPPS/ASC proposed rule (75 FR 46356), was used in Addendum BB to that proposed rule to indicate covered ancillary services for which we proposed a change in the ASC payment indicator to reflect a proposed change in the OPPS treatment of the service for CY 2011.

Except for the Level II HCPCS codes listed in Table 41 of the CY 2011 OPPS/ASC proposed rule (75 FR 46327), all ASC covered ancillary services and their proposed payment indicators for CY 2011 were included in Addendum BB to that proposed rule.

We did not receive any public comments on our proposal. Therefore, we are finalizing, without modification, our proposal to update the ASC list of covered ancillary services to reflect the payment status for the services under the OPPS. All CY 2011 ASC covered ancillary services and their final payment indicators are included in Addendum BB to this final rule with comment period.

D. ASC Payment for Covered Surgical Procedures and Covered Ancillary Services

1. Payment for Covered Surgical Procedures

a. Background

Our ASC payment policies for covered surgical procedures under the revised ASC payment system are fully described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66828 through 66831). Under our established policy for the revised ASC payment system, the ASC standard ratesetting methodology of multiplying the ASC relative payment weight for the procedure by the ASC conversion factor for that same year is used to calculate the national unadjusted payment rates for procedures with payment indicator "G2." For procedures assigned payment indicator "A2," our final policy established blended rates to be used during the transitional period and, beginning in CY 2011, ASC rates calculated according to the ASC standard ratesetting methodology. The rate calculation established for device intensive procedures (payment indicators "H8" and "J8") is structured so that the packaged device payment amount is the same as under the OPPS, and only the service portion of the rate is subject to the ASC standard ratesetting methodology. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60596 through 60629), we updated the CY 2009 ASC payment rates for ASC covered surgical procedures with payment indicators of "A2," "G2," "H8," and "J8" using CY 2008 data, consistent with the CY 2010 OPPS update. Payment rates for device-intensive procedures also were updated to incorporate the CY 2010 OPPS device offset percentages.

Payment rates for office-based procedures (payment indicators "P2," "P3," and "R2") are the lower of the MPFS non-facility PE RVU amount (we refer readers to the CY 2011 MPFS final rule with comment period) or the amount calculated using the ASC standard ratesetting methodology for the procedure. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60596 through 60629), we updated the payment amounts for office-based procedures (payment indicators "P2," "P3," and "R2") using the most recent available MPFS and OPPS data. We compared the estimated CY 2010 rate for each of the office-based procedures, calculated according to the ASC standard ratesetting methodology, to the MPFS nonfacility PE RVU amount (multiplied by the conversion factor) to determine which was lower and, therefore, would be the CY 2010 payment rate for the procedure according to the final policy of the revised ASC payment system (§ 416.171(d)).

b. Update to ASC-Covered Surgical Procedure Payment Rates for CY 2011

In the CY 2011 OPPS/ASC proposed rule (75 FR 46342 through 46343), we proposed to update ASC payment rates for CY 2011 using the established rate calculation methodologies under § 416.171. Under § 416.171(c)(4), the transitional payment rates are no longer used for CY 2011 and subsequent calendar years for a covered surgical procedure designated in accordance with § 416.166. Thus, we proposed to calculate CY 2011 payments for procedures formerly subject to the transitional payment methodology (payment indicators "A2" and "H8") using the proposed CY 2011 ASC rate calculated according to the ASC standard ratesetting methodology, incorporating the device-intensive procedure methodology, as appropriate, for procedures assigned ASC payment indicator "H8." We did not propose to modify the payment indicators for procedures that were subject to transitional payment prior to CY 2011 but will consider doing so in future rulemaking. We proposed to continue to use the amount calculated under the ASC standard ratesetting methodology for procedures assigned payment indicator "G2."

We proposed that payment rates for office-based procedures (payment indicators "P2," "P3," and "R2") and device-intensive procedures that were not subject to transitional payment (payment indicator "J8") be calculated according to our established policies, incorporating the device-intensive procedure methodology as appropriate. Thus, we proposed to update the payment amounts for device-intensive procedures based on the CY 2011 OPPS proposal that reflects updated OPPS device offset percentages, and to make payment for office-based procedures at the lesser of the CY 2011 proposed MPFS non-facility PE RVU amount or the proposed CY 2011 ASC payment amount calculated according to the standard ratesetting methodology.

Comment: One commenter did not understand the rationale for the payment rate for the following CPT codes: (1) CPT code 62319 (injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)), which the commenter stated should be paid at a rate similar to CPT codes 62318 (injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic), 62310 (injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic); or 62311 (injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)); (2) CPT code 64410 (injection, anesthetic agent; phrenic nerve), which the commenter stated should be paid at a rate similar to CPT codes 64415 (injection, anesthetic agent; brachial plexus, single), 64417 (injection, anesthetic agent; axillary nerve), or 64420 (injection, anesthetic agent; intercostal nerve, single); and (3) CPT code 64626 (destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level), which the commenter stated should be paid at rate similar to CPT code 64622 (destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level).

Response: We reviewed the proposed payment rates, payment indicators, and OPPS APC assignments for these three procedures and found that they are all correct. Because these procedures are assigned payment indicator "A2" under the revised ASC payment system, their payment is calculated using the ASC standard ratesetting methodology of multiplying the ASC relative payment weight for the procedure by the ASC conversion factor for the same year. We do not agree with the commenter that there is any basis to deviate from our standard ratesetting methodology for these procedures under the revised ASC payment system. The standard ASC methodology is based on OPPS APC groups; since these codes are assigned to different APCs, different payment rates are appropriate for these codes.

After consideration of the public comment we received, we are finalizing our CY 2011 proposal, without modification, to calculate the CY 2011 final ASC payment rates for ASC-covered surgical procedures according to our established methodologies.

c. Adjustment to ASC Payments for No Cost/Full Credit and Partial Credit Devices

Our ASC policy with regard to payment for costly devices implanted in ASCs at no cost or with full or partial credit as set forth in § 416.179 is consistent with the OPPS policy. The CY 2011 OPPS APCs and devices subject to the adjustment policy are discussed in section IV.B.2. of this final rule with comment period. The established ASC policy includes adoption of the OPPS policy for reduced payment to providers when a specified device is furnished without cost or with full or partial credit for the cost of the device for those ASC covered surgical procedures that are assigned to APCs under the OPPS to which this policy applies. We refer readers to the CY 2009 OPPS/ASC final rule with comment period for a full discussion of the ASC payment adjustment policy for no cost/full credit and partial credit devices (73 FR 68742 through 68745).

In the CY 2011 OPPS/ASC proposed rule (75 FR 46343), consistent with the OPPS, we proposed to update the list of ASC covered device intensive procedures and devices that would be subject to the no cost/full credit and partial credit device adjustment policy for CY 2011. Table 50 of the CY 2011 OPPS/ASC proposed rule (75 FR 46344 through 46346) displayed the ASC covered device-intensive procedures that we proposed would be subject to the no cost/full credit and partial credit device adjustment policy for CY 2011. Specifically, when a procedure that is listed in Table 50 is performed to implant a device that is listed in Table 51 of the CY 2011 OPPS/ASC proposed rule (75 FR 46347), where that device is furnished at no cost or with full credit from the manufacturer, the ASC would append the HCPCS "FB" modifier on the line with the procedure to implant the device. The contractor would reduce payment to the ASC by the device offset amount that we estimate represents the cost of the device when the necessary device is furnished without cost to the ASC or with full credit. We would provide the same amount of payment reduction based on the device offset amount in ASCs that would apply under the OPPS under the same circumstances. We stated in the CY 2011 OPPS/ASC proposed rule (75 FR 46343) that we continue to believe that the reduction of ASC payment in these circumstances is necessary to pay appropriately for the covered surgical procedure being furnished by the ASC.

We also proposed to reduce the payment for implantation procedures listed in Table 50 of the CY 2011 OPPS/ASC proposed rule by one-half of the device offset amount that would be applied if a device was provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the cost of the new device. The ASC would append the HCPCS "FC" modifier to the HCPCS code for a surgical procedure listed in Table 50 of the CY 2011 OPPS/ASC proposed rule when the facility receives a partial credit of 50 percent or more of the cost of a device listed in Table 51 of the CY 2011 OPPS/ASC proposed rule. In order to report that they received a partial credit of 50 percent or more of the cost of a new device, ASCs would have the option of either: (1) Submitting the claim for the device replacement procedure to their Medicare contractor after the procedure's performance but prior to manufacturer acknowledgment of credit for the device, and subsequently contacting the contractor regarding a claim adjustment once the credit determination is made; or (2) holding the claim for the device implantation procedure until a determination is made by the manufacturer on the partial credit and submitting the claim with the "FC" modifier appended to the implantation procedure HCPCS code if the partial credit is 50 percent or more of the cost of the replacement device. Beneficiary coinsurance would continue to be based on the reduced payment amount.

We did not receive any comments on our CY 2011 proposal to continue the no cost/full credit and partial credit device adjustment policy for ASCs. For CY 2011, as we proposed, we will reduce the payment for the device implantation procedures listed in Table 61, below, by the full device offset amount for no cost/full credit cases. ASCs must append the modifier "FB" to the HCPCS procedure code when the device furnished without cost or with full credit is listed in Table

62, below, and the associated implantation procedure code is listed in Table 61 In addition, for CY 2011, we will reduce the payment for implantation procedures listed in Table 61 by one half of the device offset amount that would be applied if a device were provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the device cost. If the ASC receives a partial credit of 50 percent or more of the cost of a device listed in Table 62, the ASC must append the modifier "FC" to the associated implantation procedure code if the procedure is listed in Table 61. We note that, as discussed in section II.A.2.d.9. of this final rule with comment period, CPT code 64573 (incision for implantation of neurostimulator electrodes; cranial nerve), which we had proposed to continue to recognize as subject to the no cost/full credit and partial credit device adjustment for ASCs in CY 2011, is being deleted effective January 1, 2011, and is being replaced by CPT code 64568 (incision for implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator). As we discuss in that section, we are deleting APC 0225 (Implantation of Neurostimulator Electrodes, Cranial Nerve), the APC to which CPT code 64573 was the only code assigned in CY 2010, and creating new APC 0318 (Implantation of Cranial Neurostimulator Pulse Generator and Electrode) to which we are assigning CPT code 64568. Because CPT code 64568 is replacing CPT code 64573, we are recognizing CPT code 64568 as subject to the no cost/full credit and partial credit device adjustment for ASCs in CY 2011. These CPT and APC changes are reflected in Table 61, below.

TABLE 61—CY 2011 PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY APPLIES

CY 2011 CPT Code	CY 2011 Short descriptor	Final CY 2011 ASC payment indicator	Final CY 2011 OPPS APC	OPPS APC Title	Final CY 2011 OPPS full APC offset percentage	Final CY 2011 OPPS partial APC offset percentage
24361	Reconstruct elbow joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59	30
24363	Replace elbow joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59	30
24366	Reconstruct head of radius	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59	30
25441	Reconstruct wrist joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59	30
25442	Reconstruct wrist joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59	30
25446	Wrist replacement	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59	30
27446	Revision of knee joint	J8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59	30
33206	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	71	35
33207	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	71	35
33208	Insertion of heart pacemaker	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	74	37
33212	Insertion of pulse generator	H8	0090	Insertion/Replacement of Pacemaker Pulse Generator.	73	36
33213	Insertion of pulse generator	H8	0654	Insertion/Replacement of a permanent dual chamber pacemaker.	74	37
33214	Upgrade of pacemaker system	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	74	37
33224	Insert pacing lead & connect	J8	0418	Insertion of Left Ventricular Pacing Elect.	73	36
33225	Lventric pacing lead add-on	J8	0418	Insertion of Left Ventricular Pacing Elect.	73	36
33240	Insert pulse generator	J8	0107	Insertion of Cardioverter-Defibrillator.	88	44
33249	Eltrd/insert pace-defib	J8	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	87	44
33282	Implant pat-active ht record	J8	0680	Insertion of Patient Activated Event Recorders.	71	35
53440	Male sling procedure	H8	0385	Level I Prosthetic Urological Procedures.	61	31
53444	Insert tandem cuff	H8	0385	Level I Prosthetic Urological Procedures.	61	31

TABLE 61—CY 2011 PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY APPLIES—Continued

CY 2011 CPT Code	CY 2011 Short descriptor	Final CY 2011 ASC payment indicator	Final CY 2011 OPPS APC	OPPS APC Title	Final CY 2011 OPPS full APC offset percentage	Final CY 2011 OPPS partial APC offset percentage
53445	Insert uro/ves nck sphincter	H8	0386	Level II Prosthetic Urological Procedures.	71	36
53447	Remove/replace ur sphincter	H8	0386	Level II Prosthetic Urological Procedures.	71	36
54400	Insert semi-rigid prosthesis	H8	0385	Level I Prosthetic Urological Procedures.	61	31
54401	Insert self-contd prosthesis	H8	0386	Level II Prosthetic Urological Procedures.	71	36
54405	Insert multi-comp penis pros	H8	0386	Level II Prosthetic Urological Procedures.	71	36
54410	Remove/replace penis prosth	H8	0386	Level II Prosthetic Urological Procedures.	71	36
54416	Remv/repl penis contain pros	H8	0386	Level II Prosthetic Urological Procedures.	71	36
61885	Insrt/redo neurostim 1 array	H8	0039	Level I Implantation of Neurostimulator Generator.	86	43
61886	Implant neurostim arrays	H8	0315	Level II Implantation of Neurostimulator Generator.	88	44
62361	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device.	81	41
62362	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device.	81	41
63650	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes.	58	29
63655	Implant neuroelectrodes	J8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	64	32
63685	Insrt/redo spine n generator	H8	0039	Level I Implantation of Neurostimulator Generator.	86	43
64553	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes.	58	29
64555	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes.	58	29
64560	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes.	58	29
64561	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes.	58	29
64565	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes.	58	29
64568	Implant neuroelectrodes	H8	0318	Implantation of Neurostimulator Electrodes, Cranial Nerve.	85	43
64575	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	64	32
64577	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	64	32
64580	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	64	32
64581	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr.	64	32
64590	Insrt/redo pn/gastr stimul	H8	0039	Level I Implantation of Neurostimulator Generator.	86	43
69714	Implant temple bone w/stimul	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59	30
69715	Temple bne implnt w/stimulat	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59	30
69717	Temple bone implant revision	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59	30
69718	Revise temple bone implant	H8	0425	Level II Arthroplasty or Implantation with Prosthesis.	59	30
69930	Implant cochlear device	H8	0259	Level VII ENT Procedures	85	43

TABLE 62—DEVICES FOR WHICH THE "FB" OR "FC" MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE IN CY 2011 WHEN FURNISHED AT NO COST OR WITH FULL OR PARTIAL CREDIT

CY 2011 device HCPCS code	CY 2011 short descriptor
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1764	Event recorder, cardiac.
C1767	Generator, neurostim, imp.
C1771	Rep dev, urinary, w/sling.
C1772	Infusion pump, programmable.
C1776	Joint device (implantable).
C1778	Lead, neurostimulator.
C1779	Lead, pmkr, transvenous VDD.
C1785	Pmkr, dual, rate-resp.
C1786	Pmkr, single, rate-resp.
C1813	Prosthesis, penile, inflatab.
C1815	Pros, urinary sph, imp.
C1820	Generator, neuro rechg bat sys.
C1881	Dialysis access system.
C1882	AICD, other than sing/dual.
C1891	Infusion pump, non-prog, perm.
C1897	Lead, neurostim, test kit.
C1898	Lead, pmkr, other than trans.
C1900	Lead coronary venous.
C2619	Pmkr, dual, non rate-resp.
C2620	Pmkr, single, non rate-resp.
C2621	Pmkr, other than sing/dual.
C2622	Prosthesis, penile, non-inf.
C2626	Infusion pump, non-prog, temp.
C2631	Rep dev, urinary, w/o sling.
L8614	Cochlear device/system.
L8680	Implt neurostim elctr each.
L8685	Implt nrostm pls gen sng rec.
L8686	Implt nrostm pls gen sng non.
L8687	Implt nrostm pls gen dua rec.
L8688	Implt nrostm pls gen dua non.
L8690	Aud osseo dev, int/ext comp.

d. Waiver of Coinsurance and Deductible for Certain Preventive Services

As discussed in detail in section XII.B. of the CY 2011 OPPS/ASC proposed rule (75 FR 46310 through 46316) and in the CY 2011 MPFS proposed rule (75 FR 40129 through 40136), sections 4104(b) and 10406 of the Affordable Care Act amended section 1833(a)(1) of the Act, in pertinent part, to waive the coinsurance for those preventive services under section 1861(ddd)(3)(A) of the Act as described in section 1861(ww)(2) of the Act (excluding electrocardiograms) that are recommended by the USPSTF with a grade of A or B for any indication or population and that are appropriate for the individual. Section 4104(c) of the Affordable Care Act amended section 1833(b)(1) of the Act to waive the Part B deductible for these preventive services. These provisions apply to these items and services furnished in ASCs on or after January 1, 2011. In section XII.B. of the CY 2011 OPPS/ASC proposed rule (75 FR 46310 through 46316) and in the CY 2011 MPFS proposed rule (75 FR 40129 through 40136), we proposed to define the preventive services to which this provision applies and to apply the criteria specified in section 4104 of the Affordable Care Act for the waiver of coinsurance and deductible.

Table 52 of the CY 2011 OPPS/ASC proposed rule (75 FR 46348 through 46350) identified the ASC covered surgical and ancillary services that we proposed to include in the definition of preventive services in section XII.B. of the proposed rule and in the CY 2011 MPFS proposed rule. All of the ASC covered surgical and ancillary services that are included in the chart below are preventive services that are recommended by the USPSTF with a grade of A or B. Therefore, we proposed to update § 416.160(a)(4) and add new § 416.160(a)(5) on the scope and basis of the ASC regulations and to update § 410.152(i) to reflect the waiver of coinsurance and deductible for these services.

Comment: Several commenters supported CMS' proposed implementation of the Affordable Care Act provision to waive beneficiary cost sharing for preventive services identified in section 1861(ddd)(3)(A) of the Act, and recommended by the USPSTF with a grade of A or B for any indication or population that are appropriate for the individual, and urged CMS to finalize the proposed policy.

Response: We appreciate commenters' support of our proposed implementation of sections 4104 and 10406 of the Affordable Care Act.

After consideration of the public comments we received, we are finalizing our proposal, without modification, to waive beneficiary cost sharing for preventive services identified in section 1861(ddd)(3)(A) of the Act, and recommended by the USPSTF with a grade of A or B for any indication or population that are appropriate for the individual. Table 63, below, identifies the ASC covered surgical and ancillary services that are included in the definition of preventive services in section XII.B. of this final rule with comment period and in the CY 2011 MPFS final rule with comment period. All of the ASC covered surgical and ancillary services that are included in the chart below are preventive services that are recommended by the USPSTF with a grade of A or B. We note that, as reflected in Table 63, effective January 1, 2011, CPT code 90658 is no longer payable under the ASC payment system and has been replaced by the following HCPCS codes: Q2035 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria)), Q2036 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval)), Q2037 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin)), Q2038 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone)), and Q2039 (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)).

We also are implementing our proposal, without modification, to update § 416.160(a)(4) and add new § 416.160(a)(5) on the scope and basis of the ASC regulations and to update § 410.152(i) to reflect the waiver of coinsurance and deductible for these services.

TABLE 63—CY 2011 ASC PREVENTIVE SERVICES FOR WHICH COINSURANCE AND DEDUCTIBLE ARE WAIVED IN CY 2011

Service	CY 2011 CPT/HCPCS code	CY 2011 Long descriptor	CY 2011 Coins./deductible
Bone Mass Measurement.	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).	Waived.
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine).	Waived.
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).	Waived.
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine).	Waived.

TABLE 63—CY 2011 ASC PREVENTIVE SERVICES FOR WHICH COINSURANCE AND DEDUCTIBLE ARE WAIVED IN CY 2011—Continued

Service	CY 2011 CPT/ HCPCS code	CY 2011 Long descriptor	CY 2011 Coins./ deductible
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).	Waived.
	77083	Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), 1 or more sites.	Waived.
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method.	Waived.
Colorectal Cancer Screening.	G0104	Colorectal cancer screening; flexible sigmoidoscopy	Waived.
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk	Waived.
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk.	Waived.
Influenza Virus Vaccine.	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6–35 months of age, for intramuscular use.	Waived.
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use.	Waived.
	90657	Influenza virus vaccine, split virus, when administered to children 6–35 months of age, for intramuscular use.	Waived.
	Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria).	Waived.
	Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval).	Waived.
	Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin).	Waived.
	Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone).	Waived.
	Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified).	Waived.
	90660	Influenza virus vaccine, live, for intranasal use	Waived.
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use.	Waived.
	G9141	Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family).	Waived.
	G9142	Influenza a (h1n1) vaccine, any route of administration	Waived.
Pneumococcal Vaccine.	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use.	Waived.
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	Waived.
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use.	Waived.
Hepatitis B Vaccine	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use.	Waived.
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use	Waived.
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use.	Waived.
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use	Waived.
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use.	Waived.

Section 4104(c) of the Affordable Care Act amended section 1833(b) of the Act to waive the Part B deductible for colorectal cancer screening tests that become diagnostic. Specifically, section 4104(c)(2) of the Affordable Care Act waives the deductible with respect to a colorectal cancer screening test "regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test." As discussed in section XII.B.3. of the CY 2011 OPPS/ASC proposed rule (75 FR 46317) and in the CY 2011 MPFS proposed rule (75 FR 40136), we proposed that all surgical services furnished on the same date as a planned screening colonoscopy or planned flexible sigmoidoscopy would be considered as being "furnished in connection with, as a result of, and in the same clinical encounter as the screening test." We stated that we believe this interpretation is appropriate because we believe that it would be very rare for an unrelated surgery to occur on the same date as one of these scheduled screening tests. Moreover, we stated that we believe that the risk of improper expenditures would be very small under this policy because it is the deductible, and not the coinsurance, that is waived for the related procedures other than the screening tests. In the event of a legislative change to this policy (for example, a statutory change that would waive the coinsurance for these related services in addition to the deductible), we stated that we would reassess the appropriateness of this proposed definition of services that are furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test that becomes diagnostic. We also noted that the annual deductible would likely be met when any surgical procedure (related or not) is performed on the same day as the scheduled screening test.

We proposed to implement this provision by creating a HCPCS modifier that ASCs would append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code. The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance or copayment would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

Comment: Several commenters supported CMS' proposal to extend the waiver on the deductible to surgical services provided on the same date as a colorectal cancer screening test, such as a planned screening colonoscopy or planned flexible sigmoidoscopy, when these become diagnostic. Commenters supported the proposed creation of a HCPCS modifier that would be appended to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code when the screening test becomes a diagnostic service.

Response: We appreciate commenters' support of our proposed implementation of section 4104(c) of the Affordable Care Act.

After consideration of the public comments we received, we are finalizing our proposal, without modification, that all surgical services furnished on the same date as a planned screening colonoscopy or planned flexible sigmoidoscopy be viewed as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test for purposes of implementing section 4104(c)(2) of the Affordable Care Act. We are creating new HCPCS modifier "PT," effective January 1, 2011, that ASCs will append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code when the screening test becomes a diagnostic service.

2. Payment for Covered Ancillary Services

a. Background

Our final payment policies under the revised ASC payment system for covered ancillary services vary according to the particular type of service and its payment policy under the OPPS. Our overall policy provides separate ASC payment for certain ancillary items and services integrally related to the provision of ASC covered surgical procedures that are paid separately under the OPPS and provides packaged ASC payment for other ancillary items and services that are packaged under the OPPS. Thus, we established a final policy to align ASC payment bundles with those under the OPPS (72 FR 42495).

Our ASC payment policies provide separate payment for drugs and biologicals that are separately paid under the OPPS at the OPPS rates, while we pay for separately payable radiology services at the lower of the MPFS non-facility PE RVU (or technical component) amount or the rate calculated according to the ASC standard ratesetting methodology (72 FR 42497). In all cases, ancillary items and services must be provided integral to the performance of ASC covered surgical procedures for which the ASC bills Medicare, in order for those ancillary services also to be paid.

ASC payment policy for brachytherapy sources generally mirrors the payment policy under the OPPS. We finalized our policy in the CY 2008 OPPS/ASC final rule with comment period (72 FR 42499) to pay for brachytherapy sources applied in ASCs at the same prospective rates that were adopted under the OPPS or, if OPPS rates were unavailable, at contractor-priced rates. Subsequent to publication of that rule, section 106 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) mandated that, for the period January 1, 2008 through June 30, 2008, brachytherapy sources be paid under the OPPS at charges adjusted to cost. Therefore, consistent with our final overall ASC payment policy, we paid ASCs at contractor-priced rates for brachytherapy sources provided in ASCs during that period of time. Beginning July 1, 2008, brachytherapy sources applied in ASCs were to be paid at the same prospectively set rates that were finalized in the CY 2008 OPPS/ASC final rule with comment period (72 FR 67165 through 67188). Immediately prior to the publication of the CY 2009 OPPS/ASC proposed rule, section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) amended section 1833(t)(16)(C) of the Act (as amended by section 106 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. 110–173) to extend the requirement that brachytherapy sources be paid under the OPPS at charges adjusted to cost through December 31, 2009. Therefore, consistent with final ASC payment policy, ASCs continued to be paid at contractor-priced rates for brachytherapy sources provided integral to ASC covered surgical procedures during that period of time.

Other separately paid covered ancillary services in ASCs, specifically corneal tissue acquisition and device categories with OPPS pass-through status, do not have prospectively established ASC payment rates according to the final policies of the revised ASC payment system (72 FR 42502 and 42509; § 416.164(b)). Under the revised ASC payment system, corneal tissue acquisition is paid based on the invoiced costs for acquiring the corneal tissue for transplantation. As discussed in section IV.A.1. of this final rule with comment period, new pass-through device categories may be established on a quarterly basis. One new device category eligible for pass-through payment under the OPPS and, therefore, under the ASC payment system, described by HCPCS code C1749 (Endoscope, retrograde imaging/illumination colonoscope device (Implantable), was announced in the October 2010 ASC CR (Transmittal 2045, Change Request 7147, dated September 10, 2010). Payment for HCPCS code C1749 under the ASC payment system is contractor priced.

b. Payment for Covered Ancillary Services for CY 2011

In the CY 2011 OPPS/ASC proposed rule (75 FR 46351), for CY 2011, we proposed to update the ASC payment rates and make changes to ASC payment indicators as necessary to maintain consistency between the OPPS and ASC payment system regarding the packaged or separately payable status of services and the proposed CY 2011 OPPS and ASC payment rates. The proposed CY 2011 OPPS payment methodologies for separately payable drugs and biologicals and brachytherapy sources were discussed in sections V. and VII. of the CY 2011 OPPS/ASC proposed rule (75 FR 46257 through 46283 and 46286 through 46289), respectively, and we proposed to set the CY 2011 ASC payment rates for those services equal to the proposed CY 2011 OPPS rates.

Consistent with established ASC payment policy (72 FR 42497), the proposed CY 2011 payment for separately payable covered radiology services was based on a comparison of the CY 2011 proposed MPFS non-facility PE RVU amounts (we refer readers to the CY 2011 MPFS proposed rule) and the proposed CY 2011 ASC payment rates calculated according to the ASC standard ratesetting methodology and then set at the lower of the two amounts. Alternatively, payment for a radiology service may be packaged into the payment for the ASC

covered surgical procedure if the radiology service is packaged under the OPPS. The payment indicators in Addendum BB of the CY 2011 OPPS/ASC proposed rule indicated whether the proposed payment rates for radiology services are based on the MPFS nonfacility PE RVU amount or the ASC standard ratesetting methodology, or whether payment for a radiology service is packaged into the payment for the covered surgical procedure (payment indicator "N1"). Radiology services that we proposed to pay based on the ASC standard ratesetting methodology are assigned payment indicator "Z2" (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight) and those for which the proposed payment is based on the MPFS non-facility PE RVU amount are assigned payment indicator "Z3" (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS non-facility PE RVUs).

All covered ancillary services and their proposed payment indicators were listed in Addendum BB to the CY 2011 OPPS/ASC proposed rule.

Comment: One commenter expressed continued disagreement with the ASC packaging policy related to discography services. Although it is not completely clear what the commenter was requesting, we infer that the commenter questioned the appropriateness of packaging payment for discography services. According to the commenter, the injection procedures reported by CPT codes 62290 (Injection procedure for discography, each level; lumbar) and 62291 (Injection procedure for discography, each level; cervical or thoracic) are packaged into the services reported by CPT codes 72285 (Discography, cervical or thoracic, radiological supervision and interpretation) and 72295 (Discography, lumbar, radiological supervision and interpretation) and, therefore, payment is made to an ASC only when the radiology service is provided integral to a covered surgical procedure. The commenter asserted that discography should be a separately payable service in an ASC and that the ASC payment should be 62 percent of OPPS payments.

Response: As we explained fully in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68747) and the CY 2010 OPPS/ASC final rule with comment period (74 FR 60619), we continue to believe that our packaging policy for discography services is appropriate and we do not agree that packaging policies under the ASC payment system should vary from those under the OPPS. Also, we continue to believe that discography is a radiology service, even though a component of it may be defined as surgical, and that radiology services are not appropriate for performance and separate payment in ASCs unless they are integral to covered surgical procedures.

Comment: One commenter argued that it is inappropriate to use the MPFS-based payment methodology for nuclear medicine procedures in the ASC setting without providing separate payment for diagnostic radiopharmaceuticals. According to the commenter, under the MPFS, a separate payment is made for the radiopharmaceutical used with the nuclear medicine procedure, while under the ASC payment system, payment for the radiopharmaceutical is currently packaged. The commenter asserted that, therefore, basing ASC payment on the MPFS non-facility PE RVU without separate payment for the radiopharmaceutical leaves the ASC uncompensated for the diagnostic radiopharmaceutical cost. The commenter recommended that CMS establish a separate payment methodology for diagnostic radiopharmaceuticals in the ASC setting.

Response: We do not agree with the commenter that we should establish separate payment for diagnostic radiopharmaceuticals under the ASC payment system, because we follow the OPPS packaging policies which require that payment for these items is always packaged. However, we understand the commenter's concern about the MPFS non-facility PE RVU amounts not reflecting the diagnostic radiopharmaceutical costs. Therefore, for CY 2011, we are setting the payment indicators for all nuclear medicine procedures (defined as CPT codes in the range of 78000 through 78999) that are designated as radiology services that are paid separately when provided integral to a surgical procedure on the ASC list to "Z2" so that payment for these procedures will be made based on the OPPS relative payment weight rather than the MPFS non-facility PE RVU amount, regardless of which is lower. We will consider whether and how we should change the payment policy for nuclear medicine procedures under the ASC payment system in future rulemaking.

After consideration of the public comments we received, we are providing CY 2011 payment for covered ancillary services in accordance with the final policies of the revised ASC payment system as described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 42493 through 42508), with one modification. As described above, we are setting the payment indicators for all nuclear medicine procedures (defined as CPT codes in the range of 78000 through 78999) that are designated as radiology services that are paid separately when provided integral to a surgical procedure on the ASC list to "Z2" for CY 2011 so that payment for these procedures will be made based on the OPPS relative payment weight rather than the MPFS non-facility PE RVU amount, regardless of which is lower. Covered ancillary services and their final CY 2011 payment indicators are listed in Addendum BB to this final rule with comment period.

E. New Technology Intraocular Lenses (NTIOLs)

1. Background

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68176), we finalized our current process for reviewing applications to establish new active classes of new technology intraocular lenses (NTIOLs) and for recognizing new candidate intraocular lenses (IOLs) inserted during or subsequent to cataract extraction as belonging to a NTIOL class that is qualified for a payment adjustment. Specifically, we established the following process:

- We announce annually in the **Federal Register** a document that proposes the update of ASC payment rates for the following calendar year, a list of all requests to establish new NTIOL classes accepted for review during the calendar year in which the proposal is published and the deadline for submission of public comments regarding those requests. In accordance with section 141(b)(3) of Public Law 103–432 and our regulations at § 416.185(b), the deadline for receipt of public comments is 30 days following publication of the list of requests.
- In the **Federal Register** document that finalizes the update of ASC payment rates for the following calendar year, we—
  - Provide a list of determinations made as a result of our review of all new class requests and public comments; and
  - Announce the deadline for submitting requests for review of an application for a new NTIOL class for the following calendar year.

In determining whether a lens belongs to a new class of NTIOLs and whether the ASC payment amount for insertion of that lens in conjunction with cataract surgery is appropriate, we expect that

the insertion of the candidate IOL would result in significantly improved clinical outcomes compared to currently available IOLs. In addition, to establish a new NTIOL class, the candidate lens must be distinguishable from lenses already approved as members of active or expired classes of NTIOLs that share a predominant characteristic associated with improved clinical outcomes that was identified for each class. Furthermore, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68227), we finalized our proposal to base our determinations on consideration of the following factors set out at § 416.195:

- The IOL must have been approved by the FDA and claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison with currently available IOLs must have been approved by the FDA for use in labeling and advertising;
- The IOL is not described by an active or expired NTIOL class; that is, it does not share the predominant, class-defining characteristic associated with improved clinical outcomes with designated members of an active or expired NTIOL class; and
- Evidence demonstrates that use of the IOL results in measurable, clinically meaningful, improved outcomes in comparison with use of currently available IOLs. According to the statute, and consistent with previous examples provided by CMS, superior outcomes that we consider include the following:
  - ○ Reduced risk of intraoperative or postoperative complication or trauma;
  - ○ Accelerated postoperative recovery;
  - ○ Reduced induced astigmatism;
  - ○ Improved postoperative visual acuity;
  - ○ More stable postoperative vision; and/or
  - ○ Other comparable clinical advantages, such as—
    - □ Reduced dependence on other eyewear (for example, spectacles, contact lenses, and reading glasses);
    - □ Decreased rate of subsequent diagnostic or therapeutic interventions, such as the need for YAG laser treatment;
    - □ Decreased incidence of subsequent IOL exchange; and
    - □ Decreased blurred vision, glare, other quantifiable symptom or vision deficiency.

For a request to be considered complete, we require submission of the information that is found in the guidance document entitled "Application Process and Information Requirements for Requests for a New Class of New Technology Intraocular Lens (NTIOL)" posted on the CMS Web site at: *http://www.cms.gov/ASCPayment/08_NTIOLs.asp#TopOfPage.*

As we stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68180), there are three possible outcomes from our review of a request for establishment of a new NTIOL class. As appropriate, for each completed request for consideration of a candidate IOL into a new class that is received by the established deadline, one of the following determinations is announced annually in the final rule updating the ASC payment rates for the next calendar year:

- The request for a payment adjustment is approved for the candidate IOL for 5 full years as a member of a new NTIOL class described by a new HCPCS code;
- The request for a payment adjustment is approved for the candidate IOL for the balance of time remaining as a member of an active NTIOL class; or
- The request for a payment adjustment is not approved.

We also discussed our plan to summarize briefly in the final rule with comment period the evidence that we reviewed, the public comments, and the basis for our determinations in consideration of applications for establishment of a new NTIOL class. We established that when a new NTIOL class is created, we identify the predominant characteristic of NTIOLs in that class that sets them apart from other IOLs (including those previously approved as members of other expired or active NTIOL classes) and that is associated with improved clinical outcomes. The date of implementation of a payment adjustment in the case of approval of an IOL as a member of a new NTIOL class would be set prospectively as of 30 days after publication of the ASC payment update final rule, consistent with the statutory requirement.

2. NTIOL Application Process for Payment Adjustment

In CY 2007, we posted an updated guidance document to the CMS Web site to provide process and information requirements for applications requesting a review of the appropriateness of the payment amount for insertion of an IOL to ensure that the ASC payment for covered surgical procedures includes payment that is reasonable and related to the cost of acquiring a lens that is approved as belonging to a new class of NTIOLs. This guidance document can be accessed on the CMS Web site at: *http://www.cms.gov/ASCPayment/downloads/NTIOLprocess.pdf.*

We note that we have also issued a guidance document entitled "Revised Process for Recognizing Intraocular Lenses Furnished by Ambulatory Surgery Centers (ASCs) as Belonging to an Active Subset of New Technology Intraocular Lenses (NTIOLs)." This guidance document can be accessed on the CMS Web site at: *http://www.cms.gov/ASCPayment/Downloads/Request_for_inclusion_in_current_NTIOL_subset.pdf.*

This second guidance document provides specific details regarding requests for recognition of IOLs as belonging to an existing, active NTIOL class, the review process, and information required for a request to review. Currently, there is one active NTIOL class whose defining characteristic is the reduction of spherical aberration. We accept requests throughout the year to review the appropriateness of recognizing an IOL as a member of an active class of NTIOLs. That is, review of candidate lenses for membership in an existing, active NTIOL class is ongoing and not limited to the annual review process that applies to the establishment of new NTIOL classes. We ordinarily complete the review of such a request within 90 days of receipt of all information that we consider pertinent to our review, and upon completion of our review, we notify the requestor of our determination and post on the CMS Web site notification of a lens newly approved for a payment adjustment as an NTIOL belonging to an active NTIOL class when furnished in an ASC.

3. Classes of NTIOLs Approved and New Requests for Payment Adjustment

a. Background

Since implementation of the process for adjustment of payment amounts for NTIOLs that was established in the June 16, 1999 **Federal Register**, we have approved three classes of NTIOLs, as shown in the following table, with the associated qualifying IOLs to date:

NTIOL Class	HCPCS Code	$50 Approved for services furnished on or after	NTIOL Characteristic	IOLs Eligible for adjustment
1	Q1001	May 18, 2000, through May 18, 2005.	Multifocal	Allergan AMO Array Multifocal lens, model SA40N.
2	Q1002	May 18, 2000, through May 18, 2005.	Reduction in Preexisting Astigmatism.	STAAR Surgical Elastic Ultraviolet-Absorbing Silicone Posterior Chamber IOL with Toric Optic, models AA4203T, AA4203TF, and AA4203TL.
3	Q1003	February 27, 2006, through February 26, 2011.	Reduced Spherical Aberration.	Abbott Medical Optics (AMO) Tecnis® IOL models Z9000, Z9001, Z9002, ZA9003, and AR40xEM and Tecnis® 1-Piece model ZCB00; Alcon Acrysof® IQ Model SN60WF, Acrysert Delivery System model SN60WS and Acrysof® IQ Toric model SN6ATT; Bausch & Lomb Sofport AO models LI61AO and LI61AOV and Akreos AO models AO60 and MI60, Crystalens® AT–50AO and AT–52AO; STAAR Affinity Collamer model CQ2015A and CC4204A and Elastimide model AQ2015A; Hoya model FY–60AD, FC–60AD, PY–60AD, and PC–60AD; Lenstec HD IOL.

b. Request To Establish New NTIOL Class for CY 2011

As explained in the guidance document on the CMS Web site, the deadline for each year's requests for review of the appropriateness of the ASC payment amount for insertion of a candidate IOL as a member of a new class of NTIOLs is announced in the final rule updating the ASC and OPPS payment rates for that calendar year. Therefore, a request for review for a new class of NTIOLs for CY 2011 must have been submitted to CMS by March 8, 2010, the due date published in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60621). We received one request for review to establish a new NTIOL class for CY 2011 by the March 8, 2010 due date. A summary of this request follows.

Requestor/Manufacturer: Alcon Laboratories, Inc.

Lens Model Number: Acrysof® Natural IOLs, Models: SN60WF, SN60AT, MN60MA, and MN60AC.

Summary of the Request: Alcon Laboratories, Inc. (Alcon) submitted a request for CMS to determine that its Acrysof® Natural intraocular lenses meet the criteria for recognition as NTIOL and to concurrently establish a new class of NTIOLs for blue light filtering to improve driving safety under glare conditions, with these lenses as members. As part of its request, Alcon submitted descriptive information about the candidate IOLs as outlined in the guidance document that we make available on the CMS Web site for the establishment of a new class of NTIOLs, as well as information regarding approval of the candidate IOL by the U.S Food and Drug Administration (FDA). This information included the approved labeling for the candidate lenses, a summary of the IOLs' safety and effectiveness, a copy of the FDA's approval notification, and instructions for their use. In addition, Alcon also submitted a number of studies in support of its claim that the blue light filtering design features of the candidate lenses would improve driving safety under glare conditions. We note that we have previously considered another candidate IOL for which ASC payment review was requested on the basis of blue light filtering properties. We discussed these lenses in the July 23, 2004 and March 25, 2005 NTIOL proposed and final rules published in the **Federal Register** (69 FR 44029 and 70 FR 15337, respectively).

In its CY 2011 request, Alcon asserts that its request is based on new research and measurement technologies that demonstrate that the Acrysof® Natural IOLs with a blue light filtering chromophore filters light in a manner that approximates the human crystalline lens in the 400–475 nm blue light wavelength range to reduce glare that impairs the ability of the eye to differentiate objects from the background. Alcon further states that glare reduction can help beneficiaries avoid hazards that can be caused by glare. Alcon also states that at present, there are no active or expired NTIOL classes that describe IOLs similar to its IOL.

We established in the CY 2007 OPPS/ASC final rule with comment period that when reviewing a request for recognition of an IOL as an NTIOL and a concurrent request to establish a new class of NTIOLs, we would base our determination on consideration of the three major criteria that are outlined in the discussion above. In the CY 2011 proposed rule we noted that we had begun our review of Alcon's request to recognize its Acrysof® Natural IOLs as NTIOLs and concurrently establish a new class of NTIOLs. In the CY 2011 proposed rule we solicited comment on these candidate IOLs with respect to the established NTIOL criteria as discussed above (75 FR 46354).

First, for an IOL to be recognized as an NTIOL we require that the IOL must have been approved by the FDA and claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison with currently available IOLs must have been approved by the FDA for use in labeling and advertising. We note that FDA approval for the candidate lens was granted in May 2007 and that Alcon provided FDA approval documentation, including a copy of the FDA's approval notification, the FDA's summary of the IOL's safety and effectiveness, and the labeling approved by the FDA in its request for a new class of NTIOLs. The approved labels for the Alcon IOLs all state, "Alcon's proprietary blue light filtering chromophore filters light in a manner that approximates the human crystalline lens in the 400–475 nm blue light wavelength range." The FDA label

does not otherwise reference specific clinical benefits or lens characteristics of blue light filtering on glare. In the CY 2011 OPPS/ASC proposed rule (75 FR 46354) we noted that we were interested in public comments on the specific clinical benefits or lens characteristics with established clinical relevance for the blue light filter effects on glare. We specifically noted that we were interested in public comments regarding the assertion that the specific blue light filter properties associated with the candidate IOLs improve driving safety via the reduction of glare.

Second, we also require that the candidate IOL not be described by an active or expired NTIOL class; that is, it does not share the predominant, class-defining characteristic associated with improved clinical outcomes with designated members of an active or expired NTIOL class. As noted in the table above regarding active and expired NTIOL classes, since implementation of the NTIOL review process that was established in the June 16, 1999 **Federal Register**, we have approved three classes of NTIOLs: Multifocal and Reduction in Preexisting Astigmatism classes, both of which were created in 2000 and expired in 2005, and the currently active Reduced Spherical Aberration class, which was created in 2006 and will expire in 2011. The class-defining characteristic specific to IOLs that are members of these classes is evident in the name assigned to the class. For example, IOLs recognized as members of the reduced spherical aberration class are characterized by their aspheric design that results in reduced spherical aberration. We refer readers to the table above for information about the NTIOL classes that have been created since the implementation of the review process. Based on this information, the candidate lens may not be described by an active or expired NTIOL class. Its proposed class-defining characteristic and associated clinical benefits that were described in the submitted request, specifically the blue light filtering properties, may not be similar to the class-defining characteristics and associated benefits of the two expired NTIOL classes, the Multifocal and Reduction in Preexisting Astigmatism classes, or to the class-defining characteristic and associated benefits of the currently active Reduced Spherical Aberration class. In the CY 2011 OPPS/ASC proposed rule we noted that we welcomed public comments that address whether the proposed class-defining characteristic and associated clinical benefits of the candidate Alcon IOLs are described by the expired or currently active NTIOL classes (75 FR 46354).

Third, our NTIOL evaluation criteria also require that an applicant submit evidence demonstrating that use of the IOL results in measurable, clinically meaningful, improved outcomes in comparison to use of currently available IOLs. We note that in the CY 2007 OPPS/ASC final rule with comment period, we sought comments as to what constitutes currently available IOLs for purposes of such comparisons, and we received several comments in response to our solicitation (71 FR 68178). We agreed with commenters that we should remain flexible with respect to our view of "currently available lenses" for purposes of reviewing NTIOL requests, in order to allow for consideration of technological advances in lenses over time. For purposes of reviewing this request to establish a new NTIOL class for CY 2011, we believe that foldable, spherical, monofocal IOLs made of acrylic, silicone, or polymethylmethacrylate materials represent the currently available lenses against which the candidate NTIOL to establish a new class should be compared. The Alcon request asserts that the proprietary blue light filtering chromophore incorporated into the design of the candidate lenses and its associated benefits makes them different from IOLs that are currently available in the U.S. market. In the CY 2011 OPPS/ASC proposed rule we again sought public comment on our view of "currently available lenses" for the purposes of this CY 2011 review (75 FR 46354).

We reviewed the evidence submitted as part of the request, including two peer-reviewed articles and two related clinical studies. The first of the submitted articles discussed the effect of the candidate lenses on glare disability, while the second article discussed the effects of glare on driving in simulated driving conditions. The requestor also submitted data from two clinical studies directly related to the submitted articles discussed above. One cross sectional study with a planned sample size of 70 subjects evaluated glare disability by comparing the candidate lenses against control lenses which did not include the blue light filtering chromophore. Results from this study suggest that subjects implanted with the applicant IOLs had significantly faster photostress recovery times than subjects who had control IOLs implanted without the blue light filtering chromophore. We noted in the CY 2011 OPPS/ASC proposed rule that this cross sectional study was ongoing; consequently the preliminary results submitted with the request only reflected 40 subjects from the planned total sample size. The requestor also submitted data from a second clinical study with a total sample size of 34 that evaluated the benefit of the blue light filtering chromophore on driving performance in patients implanted with the candidate IOLs compared to patients implanted with non blue light filtering IOLs. The results from this study suggested that incorporation of the yellow chromophore into the design of the candidate lenses reduce glare disability and thereby improve the ability of older drivers implanted with the candidate lenses to drive safely. Overall, the evidence submitted provided us with important information critical to our review of this request. However, in making our decision as to whether to establish a new class of NTIOL based on the primary characteristic of the candidate lenses, we indicated in the CY 2011 OPPS/ASC proposed rule (75 FR 46355) that we were also interested in what other information the public could contribute related to the asserted benefits of the blue light filtering optic. Specifically, we sought public comment and relevant data on the following:

- Are there other peer-reviewed data that would support or disprove the claims of clinical benefit made by the applicant?
- The presented studies compare the blue filtering optic to clear IOLs, are there other IOLs or other clinical alternatives for reducing glare?
- Is the sample size used in both studies sufficient considering all confounding variables including, but not limited to age, sex, race, time from surgery, status of eyes (which eye received the IOL or both eyes, for example) to conclude that a blue light filtering optic would reduce glare in the Medicare population?
- What kind of study design would be appropriate to prove the claim of significant clinical benefit due to glare reduction on which the new class would be based?
- Are the submitted data enough to clarify that the blue filtering optic is responsible for reduction in glare disability as asserted by applicant?

In the CY 2011 OPPS/ASC proposed rule (75 FR 46355), we welcomed public comments and relevant data specifically addressing whether use of the Alcon Acrysof® Natural IOLs result in measurable, clinically meaningful, improved outcomes in comparison with use of currently available IOLs. Additionally, in accordance with our established NTIOL review process, we sought public comments on all of the

review criteria for establishing a new NTIOL class that would be based on the ability of the Acrysof® Natural IOLs to filter blue light and subsequently help beneficiaries avoid hazards that can be caused by glare while driving. All comments on this request must have been received by September 2, 2010. In the proposed rule, we stated that the announcement of CMS' determination regarding this request will appear in this CY 2011 OPPS/ASC final rule with comment period. If a determination of membership of the candidate lens in a new or currently active NTIOL class is made, this determination would be effective 30 days following the date that this final rule with comment period is published in the **Federal Register**.

We thank the public for their comments concerning our review of the request from Alcon Laboratories, Inc. (Alcon) to establish a new class of NTIOL based on the characteristics of its Acrysof® Natural intraocular lenses. Some of the comments we received raised additional questions about the proven effectiveness of the Acrysof® Natural intraocular lenses, especially when compared to other currently available lenses. These comments and our responses to them are summarized below.

Comment: A few commenters presented several arguments suggesting that CMS recognize the Acrysof® natural IOLs as belonging to a new class of NTIOLS. With regard to our requirement that the IOL must have been approved by the FDA and that claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison with currently available IOLs must have been approved by the FDA for use in labeling and advertising, one commenter disagreed with the statement in the proposed rule that "the FDA label does not otherwise reference specific clinical benefits or lens characteristics of blue light filtering on glare" (75 FR 46354). The commenter asserted that the submitted studies established the clinical relevance of the blue-light filter in the AcrySof® Natural intraocular lens models and that the blue-light filter is described in the FDA-approved label. This same commenter indicated that no current or expired NTIOL class exists for IOLs that offer this characteristic.

This same commenter also provided feedback on CMS' request for comment on our definition of "currently available lenses," specifically with regards to this review. The commenter questioned whether polymethylmethacrylate (PMMA) IOLs should be deemed "conventional", and stated that less than 1 percent of cataract surgeries in the United States are performed with lenses made of PMMA. The commenters suggested that, after expiration of the currently active NTIOL class for aspheric-optic IOLs that reduce spherical aberration, CMS consider updating the description of conventional lenses from "spherical" to "spheric and aspheric."

With regard to establishing substantial clinical benefit, one commenter asserted that the study design utilized to assess driving performance allowed specifically for the observation of the effect of the yellow chromophore used in the design of the candidate lenses on glare disability in the absence of any other confounding factors. The commenter argued that the sample sizes used in each of the clinical studies presented were adequate to demonstrate the benefit of the blue light filtering technology to Medicare beneficiaries, and were determined such that they were sufficiently powerful to detect clinically significant differences. Specifically, the commenter noted that for one of the studies, which was based on a contralateral design, the sample size was specified for up to 70 subjects and ultimately was based on data from 52 subjects. The commenter claimed that the subjects enrolled in this study were an average age of 75.6 years old, with 53.8 percent females and were typical for patients in the Medicare population, and further asserted that subject-descriptive variables such as age, sex, and race did not impact the treatment comparison as the study was conducted using a contralateral design. The commenter asserted that the sample size for the second study was determined to be in the safety margin with a statistical power of 80 percent.

Another commenter also provided comments in support of the blue light filtering IOLS. This commenter asserted that the requestor had provided sufficient evidence to support the claims of real-world benefit alluded to in the request to establish a new class of NTIOL for the blue light filtering IOLs. This commenter offered to provide additional evidence to substantiate the requestors' claims with data gathered from an assessment of its own blue light filtering IOLs. Both of these commenters claimed that the Acrysof® Natural IOLs application to open a new NTIOL category meets the specific CMS NTIOL review criteria and that the applicant lenses are not described by current or prior subsets of NTIOLs.

Response: With regard to FDA labeling, we are not certain that the blue light filtering characteristic of the applicant IOLs specifically results in the reduction of glare in comparison with use of currently available IOLs in order to fulfill our requirement that the FDA approve the lens for characteristics with established clinical relevance in comparison with currently available IOLs for use in labeling and advertising. We discuss in more detail below our thorough review of the application and submitted studies on the applicant's lenses, as well as comments that we received. We appreciate the commenters' clarification.

We agree that the applicant lens is not described by current or prior subsets of NTIOLs. However, we note that these lenses are not unique with respect to the blue light filtering optic. As stated above, we have previously considered another candidate IOL for which ASC payment review was requested on the basis of blue light filtering properties.

With respect to our definition of "currently available IOLs," we thank the commenters for their feedback on this matter and we will carefully consider and evaluate this particular definition of "currently available lenses" for use in future reviews of NTIOL applications. As discussed in the CY 2007 OPS/ASC final rule with comment period (71 FR 68178), we continue to believe that flexibility is critical when identifying what the public considers "currently available lenses," in order to allow for consideration of technological advances in lenses over time.

Comment: Other commenters argued that NTIOL status has been a valuable resource to allow practicing physicians to attain access to IOLs that can provide additional benefits for their patients at the time of cataract surgery and that CMS should establish the new class to allow beneficiaries to gain access to technology that improves driving conditions.

Some commenters provided anecdotal information citing their clinical experiences with the applicant lenses, and asserted that elimination/reduction of glare disability with the chromophore lens is of such value to patients as to make it deserving of NTIOL status in order to encourage the utilization of this extremely important technology. One commenter asserted that the basis for the NTIOL application is unique, and that the Natural chromophore was designed to filter potentially harmful blue light, to reduce the amount of harmful light reaching the retina, without appreciable reduction in visual quality (that is, night vision, color vision, contrast sensitivity). This commenter further stated that the vast majority of the published research to date indicated that this goal had been

achieved, but did not provide specific citations.

Generally, these commenters urged that CMS establish a new class of NTIOL based on the blue light filtering characteristic for the primary purpose of offering beneficiaries access to an intraocular lens that the applicant argued offers the real world benefit of improving driving in glare conditions.

Response: We thank these commenters for their feedback and agree that Medicare beneficiaries should be allowed access to new technologies that offer substantial clinical improvement over existing technologies. However, as discussed further below, in our review of studies submitted to CMS as part of the NTIOL request and additional data submitted by commenters, we are not certain that the blue light filtering characteristic of the applicant IOLs specifically results in the reduction of glare in comparison with use of currently available IOLs. Moreover, in our review of other references submitted by commenters regarding the blue light filtering optic, we found evidence suggesting that the blue-filtering lenses could decrease best possible vision.

Comment: We also received several comments requesting that CMS disapprove this request to establish a new class of NTIOL based on the blue light characteristic. These commenters argued that there is insufficient clinical and scientific evidence to support the claim of a clinical benefit for a blue-light filtering optic. Several of these commenters asserted that the requestor's claim that use of the IOL results in substantial clinical benefit in comparison to use of currently available IOLs is not based in sound science and will increase the cost to Medicare without providing any significant additional benefit to patients. With regard to the requirement that the IOL must have been approved by the FDA and claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison with currently available IOLs must have been approved by the FDA for use in labeling and advertising, these commenters pointed out that the claim of clinical benefit—reduction of glare—is not included in the FDA label, as required by CMS. These commenters also pointed out that the use of a blue filter is not unique, further stating that another IOL manufacturer also creates IOLs with a blue light filter.

Other commenters also opposed the creation of a new NTIOL class based on the blue light filtering characteristic. With regard to the requirement that the NTIOL result in a substantial clinical benefit through measurable, clinically meaningful, improved outcomes, commenters argued that they were relatively few articles potentially related to blue light filtration and reduction of glare, and of these identified articles, only one directly addressed the specific topic. They argued that the one study, funded by the requestor, has numerous flaws in the study protocol and night driving simulator testing methodology. They asserted that it is impossible to tell whether the beneficial results associated with one of the applicant IOLs, specifically model SN60WF are due to the lens' blue light filtering optic or its aspheric optic, given that aspheric lenses have been shown to improve contrast sensitivity in mesopic conditions with and without glare. These commenters questioned the mean postoperative time for the blue light filtering IOLs (10.4 months) versus the same measure for the control IOL (4.7 years). They asserted that the disparity between the measures makes it nearly impossible to account for the clarity of the posterior capsule or the impact of progressive glistenings on light scatter. They further stated that in any IOL study one would expect visual performance to be superior at 10 months post-op versus 4 years post-op. These commenters suggested that the study uses a biased experimental glare tester, where the visual target has a different light spectrum (color) to the glare source. They explained that in almost all real-world situations, the spectrum of the glare source is similar or identical to that of the visual target. Thus, heavily weighting the glare source with short wavelength blue light does not represent real-world glare situations and would favor a performance benefit for a blue-light filtering IOL. They asserted that in a real world situation where the visual target and the glare source have the same light spectrum, a blue blocking IOL cannot reduce glare disability because it will decrease stray light in exactly the same proportion as the target brightness.

Some commenters suggested that CMS and the FDA consider mandating the withdrawal of the applicant and other similarly designed lenses from the market, or at least require that a clear lens alternative be offered for each model that the company produces so that the surgeon may take advantage of the other features of the lenses that are available without having to be forced into using yellow chromophore permeated lenses.

Another commenter provided a number of citations of studies in peer reviewed journals that supported the fact that there are no differences in the disability glare performance of pseudophakes (people who had cataract surgery with IOL replacement) with colorless versus blue-filtering IOLs. This commenter also stated that glare disability is not a scientifically proven predictor of older driver's safety and moreover, that yellow tinted, blue filtering design of the Acrysof® Natural IOL chromophores permanently limits the blue light part of the visible spectrum that aids older adults to see as well as possible. The commenter further pointed out that this type of lens undesirably restricts pseudophakic scotopic (night vision), mesopic (a combination of photopic vision and scotopic vision in low but not quite dark lighting situations), and S-cone and retinal ganglion photoreception. Finally, this commenter stated that the glistening associated with Acrysof® Natural lenses that develops overtime causes disability glare rather than reduces it. The commenter described glistenings as fluid-filled microvacuoles that form within the IOL optic when the IOL is in an aqueous environment, and noted that glistenings are observed in all types of IOLs, but have been mainly associated with hydrophobic acrylic IOLs, similar to the requestor's IOL.

Response: We appreciate all of the feedback regarding the issues posed in our proposed rule, and regarding our review of this applicant IOL. These comments have been very helpful in pointing us to additional resources relevant to the asserted connection between the blue light filtering characteristic of the applicant IOLs and the proposed benefit of glare reduction.

With regards to those comments questioning whether the FDA approved labels for the applicant IOLs included claims of clinical benefit, we note that our specific criteria asks that the FDA approved label include "[c]laims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison to currently available IOLs." While the FDA label does not include any claims regarding the asserted reduction in glare properties of the applicant lens, it does mention the blue light filtering optic which the applicant asserts is proven to have established clinical relevance. We note that having two manufacturers create an IOL with a blue-light filter or other optic is not sufficient to disqualify a request for a new class of IOL.

We have reviewed the public comments received and the available data. Although the requestor submitted several supporting studies with its application, as discussed above, commenters provided compelling evidence arguing against CMS establishing a new class of IOL for blue-

filtering. We conclude that the Acrysof® Natural IOLs do not demonstrate substantial clinical benefit in comparison with currently available IOLs. Therefore, we are disapproving Alcon's request to recognize its Acrysof® Natural IOLs as NTIOLs, and subsequently to establish a new class of NTIOL for payment in CY 2011.

4. Payment Adjustment

The current payment adjustment for a 5-year period from the implementation date of a new NTIOL class is $50. In the CY 2007 OPPS/ASC final rule with comment period, we revised § 416.200(a) through (c) to clarify how the IOL payment adjustment is made and how an NTIOL is paid after expiration of the payment adjustment, and made minor editorial changes to § 416.200(d). For CY 2008, CY 2009, and CY 2010, we did not revise the payment adjustment amount, and we did not propose to revise the payment adjustment amount for CY 2011 in light of our limited experience with the revised ASC payment system, implemented initially on January 1, 2008.

5. ASC Payment for Insertion of IOLs

In accordance with the final policies of the revised ASC payment system, for CY 2011, payment for IOL insertion procedures is established according to the standard payment methodology of the revised payment system, which multiplies the ASC conversion factor by the ASC payment weight for the surgical procedure to implant the IOL. The CY 2011 ASC payment for the cost of a conventional lens is packaged into the payment for the associated covered surgical procedures performed by the ASC. The HCPCS codes for IOL insertion procedures were included in Table 53 of the CY 2011 OPPS/ASC proposed rule (75 FR 46355), and their proposed CY 2011 payment rates were found in Addendum AA to the proposed rule.

We did not receive any public comments concerning the proposed CY 2011 payment rates for the insertion of IOL procedures. Therefore, we are finalizing the payment rates for the insertion of IOL procedures, calculated according to the standard methodology of the revised ASC payment system. The HCPCS codes for IOL insertion procedures are displayed in Table 64 below, and their final CY 2011 payment rates may be found in Addendum AA to this final rule with comment period.

TABLE 64—INSERTION OF IOL PROCEDURES

CY 2010 HCPCS code	CY 2010 Long descriptor
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure).
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification).
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal.
66986	Exchange of intraocular lens.

6. Announcement of CY 2011 Deadline for Submitting Requests for CMS Review of Appropriateness of ASC Payment for Insertion of an NTIOL Following Cataract Surgery

In accordance with § 416.185(a) of our regulations as revised by the CY 2007 OPPS/ASC final rule with comment period, CMS announces that in order to be considered for payment effective January 1, 2012, requests for review of applications for a new class of new technology, IOLs must be received at CMS by 5 p.m. EST, on March 5, 2011. Send requests to ASC/NTIOL, Division of Outpatient Care, Mailstop C4–05–17, Centers for Medicare and Medicaid, 7500 Security Boulevard, Baltimore, MD 21244–1850.

To be considered, requests for NTIOL reviews must include the information on the CMS Web site at: *http://www.cms.gov/ASCPayment/downloads/NTIOLprocess.pdf.*

F. ASC Payment and Comment Indicators

1. Background

In addition to the payment indicators that we introduced in the August 2, 2007 final rule, we also created final comment indicators for the ASC payment system in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66855). We created Addendum DD1 to define ASC payment indicators that we use in Addenda AA and BB to provide payment information regarding covered surgical procedures and covered ancillary services, respectively, under the revised ASC payment system. The ASC payment indicators in Addendum DD1 are intended to capture policy relevant characteristics of HCPCS codes that may receive packaged or separate payment in ASCs, such as whether they were on the ASC list of covered services prior to CY 2008; payment designation, such as device-intensive or office-based, and the corresponding ASC payment methodology; and their classification as separately payable ancillary services including radiology services, brachytherapy sources, OPPS pass-through devices, corneal tissue acquisition services, drugs or biologicals, or NTIOLs.

We also created Addendum DD2 that lists the ASC comment indicators. The ASC comment indicators used in Addenda AA and BB to the proposed rules and final rules with comment period serve to identify, for the revised ASC payment system, the status of a specific HCPCS code and its payment indicator with respect to the timeframe when comments will be accepted. The comment indicator "NI" is used in the OPPS/ASC final rule with comment period to indicate new HCPCS codes for the next calendar year for which the interim payment indicator assigned is subject to comment. The comment indicator "NI" is also assigned to existing codes with substantial revisions to their descriptors such that we consider them to be describing new services, as discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60622). We stated in the CY 2011 OPPS/ASC proposed rule that will respond to public comments and finalize the ASC treatment of all codes labeled with comment indicator "NI" in the CY 2011 OPPS/ASC final rule with comment period (75 FR 46356).

The "CH" comment indicator is used in Addenda AA and BB to this CY 2011 proposed rule to indicate that a new payment indicator (in comparison with the indicator for the CY 2010 ASC April quarterly update) is proposed for assignment to an active HCPCS code for the next calendar year; an active HCPCS code is proposed for addition to the list of procedures or services payable in ASCs; or an active HCPCS code is proposed for deletion at the end of the current calendar year. The "CH" comment indicators that are published in the final rule with comment period are provided to alert readers that a change has been made from one calendar year to the next, but do not indicate that the change is subject to comment. The full definitions of the payment indicators and comment indicators are provided in Addenda DD1 and DD2 to this final rule with comment period.

2. ASC Payment and Comment Indicators

In the CY 2011 OPPS/ASC proposed rule (75 FR 46356), we did not propose any changes to the definitions of the ASC payment and comment indicators for CY 2011. We stated that we will consider proposing to modify the payment indicators for procedures that were subject to transitional payment prior to CY 2011 in future rulemaking.

We did not receive any public comments on the ASC payment and comment indicators. We are finalizing our proposed CY 2011 payment and comment indicators, without modification, in Addenda DD1 and DD2 to this final rule with comment period.

G. ASC Policy and Payment Recommendations

MedPAC was established under section 1805 of the Act to advise Congress on issues affecting the Medicare program. Subparagraphs (B) and (D) of section 1805(b)(1) of the Act require MedPAC to submit reports to Congress not later than March 1 and June 15 of each year that present its Medicare payment policy reviews and recommendations and its examination of issues affecting the Medicare program, respectively. The following section describes a recent MedPAC recommendation that is relevant to the ASC payment system.

The March 2010 MedPAC "Report to the Congress: Medicare Payment Policy" included the following recommendation relating specifically to the ASC payment system for CY 2011:

Recommendation 2C: The Congress should implement a 0.6 percent increase in payment rates for ambulatory surgical center services in calendar year 2011 concurrent with requiring ambulatory surgical centers to submit cost and quality data.

CMS Response: In the August 2, 2007 final rule (72 FR 42518 through 42519), we adopted a policy to update the ASC conversion factor for consistency with section 1833(i)(2)(C) of the Act, which requires that, if the Secretary has not updated the ASC payment amounts in a calendar year, the payment amounts shall be increased by the percentage increase in the Consumer Price Index for All Urban Consumers (CPI–U) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. The statute set the update at zero for CY 2008 and CY 2009. We indicated that we planned to implement the annual updates through an adjustment to the conversion factor under the ASC payment system beginning in CY 2010 when the statutory requirement for a zero update no longer applies. Further, we noted that that we would update the conversion factor for the CY 2010 ASC payment system by the percentage increase in the CPI–U, consistent with our policy as codified under § 416.171(a)(2).

As we indicated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60622), we did not require ASCs to submit cost data to the Secretary for CY 2010. We explained that the 2006 GAO report, "Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System" (GAO–07–86), concluded that the APC groups in the OPPS reflect the relative costs of surgical procedures performed in ASCs in the same way they reflect the relative costs of the same procedures when they are performed in HOPDs. Consistent with the GAO findings, CMS is using the OPPS as the basis for the ASC payment system, which provides for an annual revision of the ASC payment rates under the budget neutral ASC payment system. In addition, we noted that, under the methodology of the revised ASC payment system, we do not utilize ASC cost information to set and revise the payment rates for ASCs but, instead, rely on the relativity of hospital outpatient costs developed for the OPPS, consistent with the recommendation of the GAO. Furthermore, we explained that we have never required ASCs to routinely submit cost data and expressed our concern that a new Medicare requirement for ASCs to do so could be administratively burdensome for ASCs. In 2009, MedPAC made a similar recommendation to that made in Recommendation 2C above. In light of that MedPAC recommendation, in the CY 2010 OPPS/ASC proposed rule (74 FR 35391), we solicited public comment on the feasibility of ASCs submitting cost information to CMS, including whether costs should be collected from a sample or the universe of ASCs, the administrative burden associated with such an activity, the form that such a submission could take considering existing Medicare requirements for other types of facilities and the scope of ASC services, the expected accuracy of such cost information, and any other issues or concerns of interest to the public on this topic.

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60623), we summarized and responded to these comments. As noted in that final rule with comment period, commenters' expressed varied opinions regarding the feasibility of requiring ASCs to submit cost data to the Secretary. Some commenters believed that requiring ASC to submit such data would not be an insurmountable obstacle and pointed out that other small facilities submit cost reports to CMS. They stated that ASC cost reports are necessary to assess the adequacy of Medicare payments and evaluate the ASC update. Other commenters, however, opposed the requirement that ASCs submit cost data to CMS because they believed such a requirement would be unnecessary and administratively burdensome. Commenters generally supported a requirement that ASCs report quality data. We refer readers to the CY 2010 OPPS/ASC final rule with comment period for a full discussion of the comments we received on the feasibility of requiring ASCs to report cost and quality data (74 FR 60623). We responded that we would keep the commenters' perspectives in mind as we further consider the adequacy of the Medicare ASC payment rates and move toward implementation of ASC quality reporting.

Consistent with our CY 2010 policy, in the CY 2011 OPPS/ASC proposed rule (75 FR 46357), we proposed not to require ASCs to submit cost data to the Secretary for CY 2011. We stated that we continue to believe that our established methodology results in appropriate payment rates for ASCs. As noted in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60623), section 109(b) of the MIEA–TRHCA (Pub. L. 109–432) gives the Secretary the authority to implement ASC quality measure reporting and to reduce the payment update for ASCs that fail to report those required measures. We restated our belief that promoting high quality care in the ASC setting through quality reporting is highly desirable and fully in line with our efforts under other payment systems. As discussed in section XVI.F. of the CY 2011 OPPS/ASC proposed rule (75 FR 46382 through 46383), we proposed not to require ASC quality data reporting for CY 2011, but stated our intention to implement ASC quality reporting in a future rulemaking.

We noted in the proposed rule that section 3006(f) of the Affordable Care Act, as added by section 10301(a) of the Affordable Care Act, requires CMS to develop a plan on implementing a value-based purchasing program for ASCs that will consider measures of quality and efficiency in ASCs, among other requirements. The Secretary must submit a report to Congress containing this plan not later than January 1, 2011.

Comment: Many commenters urged CMS to require ASCs to routinely report

cost data to allow for future validation of the relative appropriateness of ASC payment weights and rates. MedPAC commented that ASCs should be required to submit cost and quality data, concurrent with a 0.6 percent increase in ASC payment rates for CY 2011, arguing that ASC cost data are needed to examine whether an existing input price index is an appropriate proxy for the costs of ASCs or whether an ASC-specific market basket should be developed. MedPAC pointed out that businesses such as ASCs typically keep records of their costs for filing taxes and other purposes, and those other small providers such as home health agencies and hospices submit cost data to CMS. MedPAC stated that CMS should create a streamlined process for ASCs to submit cost data in order to minimize the burden on ASCs and CMS.

Other commenters, however, supported CMS' proposal not to require ASCs to routinely submit cost data, a process that the commenters characterized as administratively burdensome. The commenters stated that the quality of such data, if required, would be questionable because of the varying types of services and cost structures among ASCs and would not be suitable for ratesetting.

Many commenters, including MedPAC, urged CMS to require ASCs to report quality measures, while others supported CMS' proposal to defer quality reporting for ASCs while they adjust to the revised ASC payment system. Commenters also supported the implementation of a value-based purchasing program for ASCs.

Response: We did not propose to require ASCs to submit cost data to the Secretary for CY 2011 because, as noted previously in this section and in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60622), we continue to believe that our established methodology results in appropriate payment rates for ASCs. Therefore, we are finalizing our proposal not to require cost reporting in this final rule with comment period. We thank all of the commenters for their thoughts regarding the feasibility and value of requiring ASCs to submit cost data that could be used to evaluate the adequacy of the Medicare ASC payment rates. We will keep the commenters' perspectives about collecting cost information from ASCs in mind as we further consider the adequacy of the Medicare ASC payment rates. We also appreciate the commenters' perspectives' regarding ASC quality reporting and refer readers to section XVI.F. of this final rule with comment period for more detailed discussion of ASC quality data reporting. As mentioned in the proposed rule, a plan to implement an ASC value based purchasing program will be prepared for Congress by January 1, 2011, as required by the Affordable Care Act.

H. Calculation of the ASC Conversion Factor and ASC Payment Rates

1. Background

In the August 2, 2007 final rule (72 FR 42493), we established our policy to base ASC relative payment weights and payment rates under the revised ASC payment system on APC groups and relative payment weights. Consistent with that policy and the requirement at section 1833(i)(2)(D)(ii) of the Act that the revised payment system be implemented so that it would be budget neutral, the initial ASC conversion factor (CY 2008) was calculated so that estimated total Medicare payments under the revised ASC payment system in the first year would be budget neutral to estimated total Medicare payments under the prior (CY 2007) ASC payment system (the ASC conversion factor is multiplied by the relative payment weights calculated for many ASC services in order to establish payment rates). That is, application of the ASC conversion factor was designed to result in aggregate Medicare expenditures under the revised ASC payment system in CY 2008 equal to aggregate Medicare expenditures that would have occurred in CY 2008 in the absence of the revised system, taking into consideration the cap on ASC payments in CY 2007 as required under section 1833(i)(2)(E) of the Act (72 FR 42522).

We note that we consider the term "expenditures" in the context of the budget neutrality requirement under section 1833(i)(2)(D)(ii) of the Act to mean expenditures from the Medicare Part B Trust Fund. We do not consider expenditures to include beneficiary coinsurance and copayments. This distinction was important for the CY 2008 ASC budget neutrality model that considered payments across hospital outpatient, ASC, and MPFS payment systems. However, because coinsurance is almost always 20 percent for ASC services, this interpretation of expenditures has minimal impact for subsequent budget neutrality adjustments calculated within the revised ASC payment system.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66857 through 66858), we set out a step-by-step illustration of the final budget neutrality adjustment calculation based on the methodology finalized in the August 2, 2007 final rule (72 FR 42521 through 42531) and as applied to updated data available for the CY 2008 OPPS/ASC final rule with comment period. The application of that methodology to the data available for the CY 2008 OPPS/ASC final rule with comment period resulted in a budget neutrality adjustment of 0.65.

For CY 2008, we adopted the OPPS relative payment weights as the ASC relative payment weights for most services and, consistent with the final policy, we calculated the CY 2008 ASC payment rates by multiplying the ASC relative payment weights by the final CY 2008 ASC conversion factor of $41.401. For covered office-based surgical procedures and covered ancillary radiology services, the established policy is to set the relative payment weights so that the national unadjusted ASC payment rate does not exceed the MPFS unadjusted non-facility PE RVU amount. Further, as discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66841 through 66843), we also adopted alternative ratesetting methodologies for specific types of services (for example, device-intensive procedures).

As discussed in the August 2, 2007 final rule (72 FR 42518) and as codified under § 416.172(c) of the regulations, the revised ASC payment system accounts for geographic wage variation when calculating individual ASC payments by applying the pre-floor and pre-reclassified hospital wage indices to the labor-related share, which is 50 percent of the ASC payment amount. Beginning in CY 2008, CMS accounted for geographic wage variation in labor cost when calculating individual ASC payments by applying the pre-floor and pre-reclassified hospital wage index values that CMS calculates for payment, using updated Core-Based Statistical Areas (CBSAs) issued by the Office of Management and Budget in June 2003. The reclassification provision provided at section 1886(d)(10) of the Act is specific to hospitals. We believe the use of the most recent available raw pre-floor and pre-reclassified hospital wage indices results in the most appropriate adjustment to the labor portion of ASC costs. In addition, use of the unadjusted hospital wage data avoids further reductions in certain rural statewide wage index values that result from reclassification. We continue to believe that the unadjusted hospital wage indices, which are updated yearly and are used by many other Medicare payment systems, appropriately account for geographic variation in labor costs for ASCs.

We noted that in certain instances there might be urban or rural areas for

which there is no IPPS hospital whose wage index data would be used to set the wage index for that area. For these areas, our policy has been to use the average of the wage indices for CBSAs (or metropolitan divisions as applicable) that are contiguous to the area that has no wage index (where "contiguous" is defined as sharing a border). We have applied a proxy wage index based on this methodology to ASCs located in CBSA 25980 Hinesville-Fort Stewart, GA, and CBSA 22 Rural Massachusetts. For CY 2011, we have identified another area, specifically, CBSA 11340 Anderson, SC for which there is no IPPS hospital whose wage index data would be used to set the wage index for that area. Generally, we would use the methodology described above; however in this situation all of the areas contiguous to CBSA 11340 Anderson, SC are rural. Therefore, for this type of unique situation, in the CY 2011 OPPS/ASC proposed rule (75 FR 46358), we proposed to set the ASC wage index by calculating the average of all wage indices for urban areas in the State. In other situations, where there are no IPPS hospitals located in a relevant labor market area, we would continue our current policy of calculating an urban or rural area's wage index by calculating the average of the wage indices for CBSAs (or metropolitan divisions where applicable) that are contiguous to the area with no wage index.

Comment: Several commenters recommended that CMS adopt for the ASC payment system the same wage index values used for hospital payment under the OPPS. They believe that applying different wage indices in the ASC payment system than are used in the OPPS is inequitable because, in many market areas, ASCs compete directly with hospitals for employees with skills and functions that are applicable in both settings. The commenters also argued that applying different wage index values for ASCs and hospitals causes rates between the two systems to diverge at the local level, and that using the pre-floor and pre-reclassified hospital wage indices for ASCs is inconsistent with the principle of aligning the OPPS and ASC payment systems. They asserted that the ASC payment system is subordinate to the OPPS—the ASC conversion factor having been derived from the OPPS conversion factor and the OPPS relative weights being the annual starting point for ASC relative weights—and thus policies applicable under the OPPS should apply to the ASC setting.

The commenters believed that, in all but a few instances, the adjusted wage index values used in the OPPS would be higher than the current wage index values used in the ASC payment system. Specifically, the commenters believe the adjustments that are applied to the wage indices used in the OPPS system also should be applied to the ASC wage indices. The adjustments that commenters requested be applied to the wage index values used in the ASC payment system are: Application of the "frontier States" wage index floor of 1.0 for providers in Montana, Nevada, Wyoming, North Dakota, and South Dakota; an imputed statewide rural wage index for States with no counties outside of an urban area; a mechanism to prevent urban areas from having indices below the statewide rural wage index; a mechanism to prevent the wage index of urban areas that cross State lines from falling below the State-specific rural floor; and an adjustment for counties where a significant proportion of residents commute to other counties for work.

Response: As we have stated in the past (74 FR 60625), we continue to believe that the unadjusted hospital wage indices, which are updated yearly and are used by almost all Medicare payment systems, appropriately account for geographic variance in labor costs for ASCs. The post-reclassification wage indices for hospitals that fall under section 1886(d) of the Act ("section 1886(d) hospitals") include many statutory adjustments specific to section 1886(d) hospitals and some regulatory adjustments for section 1886(d) hospitals including, but not limited to, the areas requested by commenters: application of the "frontier States" wage index floor of 1.0 for providers in Montana, Nevada, Wyoming, North Dakota, and South Dakota; an imputed Statewide rural wage index for States with no counties outside of an urban area; a "rural floor" mechanism to prevent urban areas from having indices below the Statewide rural wage index; a mechanism to prevent the wage index of urban areas that cross State lines from falling below the State-specific rural floor; and an adjustment for counties where a significant proportion of residents commute to other counties. Because many of these adjustments are specified in statute for section 1886(d) hospitals, we believe it is appropriate to apply these adjustments only to section 1886(d) hospitals. The OPPS adopts the post-reclassification wage indices (adjusted hospital wage indices) because the majority of participating hospitals are section 1886(d) hospitals and, in these hospitals, the exact same personnel staff the ancillary departments of the hospital that simultaneously treat both inpatients and outpatients. For payment systems for other providers and suppliers for which there is no specific statutory provision for adjustments to the wage index values, we calculate and apply unadjusted hospital wage indices that reflect the reported cost of hospital labor in each area. Specifically, we use some form of the unadjusted hospital wage indices to pay long-term care, psychiatric, and inpatient rehabilitation hospitals for inpatient care, as well as skilled nursing facilities, hospice programs, home health agencies, and ESRD facilities. Historically, we have only applied the adjusted, post-reclassification hospital wage indices to pay section 1886(d) hospitals for both inpatient and outpatient services for the reasons noted above. It is our policy to treat ASCs as we do all other providers and suppliers using hospital wage index values.

Further, adopting the post-reclassification hospital wage indices with rural floor and associated statewide budget neutrality adjustment would not increase overall ASC payment because we apply a budget neutrality adjustment for changes in the wage indices to the conversion factor. Therefore, any anticipated increases in aggregate ASC payment created by adopting the post-reclassification wage indices would lead to a comparable downward adjustment to the conversion factor to ensure that the only increase in payments to ASCs are those allowed by the update factor. We discuss our budget neutrality adjustment for changes to the wage indices below in section XV.H.2.b. of this final rule with comment period.

After consideration of the public comments we received, we are continuing our established policy to account for geographic wage variation in labor cost when calculating individual ASC payments by applying the pre-floor and pre-reclassified hospital wage index values that CMS calculates for payment, using updated CBSAs. We also are implementing our proposal, without modification, to set the ASC wage index by calculating the average of all wage indices for urban areas in the State when all contiguous areas to a CBSA are rural and there is no IPPS hospital whose wage index data could be used to set the wage index for that area.

2. Calculation of the ASC Payment Rates

a. Updating the ASC Relative Payment Weights for CY 2011 and Future Years

We update the ASC relative payment weights each year using the national

OPPS relative payment weights (and MPFS non-facility PE RVU amounts, as applicable) for that same calendar year and uniformly scale the ASC relative payment weights for each update year to make them budget neutral (72 FR 42531 through 42532). Consistent with our established policy, in the CY 2011 OPPS/ASC proposed rule (75 FR 46358), we proposed to scale the CY 2011 relative payment weights for ASCs according to the following method. Holding ASC utilization and the mix of services constant from CY 2008 for CY 2011, we proposed to compare the total payment weight using the CY 2010 ASC relative payment weights under the 75/25 blend (of the CY 2007 payment rate and the ASC payment rate calculated under the ASC standard methodology) with the total payment weight using the CY 2011 ASC relative payment weights (calculated under the ASC standard ratesetting methodology) to take into account the changes in the OPPS relative payment weights between CY 2010 and CY 2011. We would use the ratio of CY 2010 to CY 2011 total payment weight (the weight scaler) to scale the ASC relative payment weights for CY 2011. The proposed CY 2011 ASC scaler was 0.9090 (75 FR 46358) and scaling would apply to the ASC relative payment weights of the covered surgical procedures and covered ancillary radiology services for which the ASC payment rates are based on OPPS relative payment weights.

Scaling would not apply in the case of ASC payment for separately payable covered ancillary services that have a predetermined national payment amount (that is, their national ASC payment amounts are not based on OPPS relative payment weights), such as drugs and biologicals that are separately paid or services that are contractor-priced or paid at reasonable cost in ASCs. Any service with a predetermined national payment amount would be included in the ASC budget neutrality comparison, but scaling of the ASC relative payment weights would not apply to those services. The ASC payment weights for those services without predetermined national payment amounts (that is, those services with national payment amounts that would be based on OPPS relative payment weights if a payment limitation did not apply) would be scaled to eliminate any difference in the total payment weight between the current year and the update year.

For any given year's ratesetting, we typically use the most recent full calendar year of claims data to model budget neutrality adjustments. At the time of the proposed rule, we had available 98 percent of CY 2009 ASC claims data. For this final rule with comment period, we have approximately 99 percent of all ASC claims data for CY 2009.

To create an analytic file to support calculation of the weight scaler and budget neutrality adjustment for the wage index (discussed below), we summarized available CY 2009 ASC claims by provider and by HCPCS code. We created a unique supplier identifier solely for the purpose of identifying unique ASCs within the CY 2009 claims data. We used the supplier zip code reported on the claim to associate State, county, and CBSA with each ASC. This file, available to the public as a supporting data file for the proposed rule, is posted on the CMS Web site at: *http://www.cms.gov/ASCPayment/01_Overview.asp#TopOfPage.*

Comment: Many commenters again expressed their opposition to scaling the ASC relative payment weights. Many of the commenters on the CY 2011 OPPS/ASC proposed rule offered the same views as the public commenters on the CY 2010 OPPS/ASC final rule with comment period and the CY 2009 OPPS/ASC final rule with comment period, the year when CMS first applied the scaling policy that was finalized in the August 2, 2007 final rule. The commenters expressed many concerns, including that scaling is contrary to the intent of using the cost-based OPPS relative payment weights as the basis for determining the relative payments for the same services in ASCs and that scaling would continue to erode the payment relationship between the OPPS and ASC payment system. They asserted that, although scaling is intended to maintain budget neutrality within the ASC payment system, it is instead creating increasingly large payment differentials between the ASC and OPPS payments for the same services without evidence of growing differences in capital and operating costs between the two settings, and depriving ASCs of real increases in the relative costs of procedures. The commenters believed that the CY 2011 OPPS relative payment weights reflected real growth in the relative costs of surgical services provided in HOPDs and that the ASC scaler should not reclaim dollars from the ASC payment system because there also has been real cost growth for the surgical services provided in ASCs. The commenters argued that only the difference in the conversion factor should drive differences in the payment for ASC and HOPD services from year to year, and that because CMS bases the ASC payment system on the OPPS relative weights, the weights should be the same in both payment systems.

The commenters also pointed out that while CMS has suggested that scaling of the relative weights is a design element that will protect ASCs from changes in the OPPS relative weights that could significantly decrease payments for certain procedures, the trend in the OPPS relative weights suggests that the scaling factor for ASCs will rarely result in an increase in ASC relative weights. According to the commenters, ASCs would have received a negative adjustment to their weights in seven of the last nine years, indicating that the application of scaling in the ASC setting will continue to hurt, rather than protect, ASCs in the future. The commenters estimated that scaling of the ASC relative payment weights will reduce ASC weights by 9 percent in CY 2011.

The commenters argued that CMS is not required to scale the ASC relative weights and that it should use its authority to suspend the application of scaling the ASC relative weights for CY 2011. They noted that the regulations establishing the revised ASC payment system give CMS the flexibility to scale "as needed." In addition, some commenters stated that Congress imposed a budget neutrality requirement on the ASC payment system only during the CY 2008 implementation year, and that CMS is under no legal obligation to continue to apply a scaling factor.

The commenters also expressed their continuing disagreement with aspects of the budget neutrality adjustment methodology used by CMS to establish the conversion factor. Specifically, they stated that CMS estimated that ASCs would grow significantly in the volume and diversity of services offered. According to the commenters, in addition to overestimating volume growth, CMS likewise overestimated the level and distribution of spending. They provided 2008 and 2009 spending data and indicated that volume has grown at the lowest rate in program history and that the diversity of services provided is largely unchanged. They believe that these findings provide a further basis for CMS not to scale the ASC relative payment weights for CY 2011 after the weights are scaled under the OPPS.

Response: Many of these comments are similar to public comments on the proposal for the revised ASC payment system that we responded to in the August 2, 2007 final rule (72 FR 42531 through 42533). For example, with regard to scaling, we addressed these same concerns raised by commenters that annual rescaling would cause

divergence of the relative weights between the OPPS and the revised ASC payment system for individual procedures in the August 2, 2007 final rule (72 FR 42532). We refer the commenters to that discussion for our detailed response in promulgating the scaling policy that was initially applied in CY 2009 (72 FR 42531 through 42533).

As we have stated in the past (74 FR 60627), the ASC weight scaling methodology is entirely consistent with the OPPS methodology for scaling the relative payment weights and, for the most part, the increasing payment differentials between the ASC and OPPS payments for the same services are not attributable to scaling ASC relative payment weights. Considerations of differences between the capital and operating costs of ASCs and HOPDs are not part of the ASC standard ratesetting methodology, which relies only on maintaining the same relativity of payments for services under the two payment systems, as well as budget neutrality within each payment system. Furthermore, unlike HOPDs, we do not have information about the costs of ASC services in order to assess differences in capital and operating costs over time between the two settings. In order to maintain budget neutrality of the ASC payment system, we need to adjust for the effects of changes in relative weights. The ASC payment system adopts the OPPS relative weights as the mechanism for apportioning total payments, after application of the update factor, among all of the services covered by the ASC payment system. The OPPS relative weights serve the same purpose in the OPPS. The OPPS relative weights do not represent an estimate of absolute cost of any given procedure; rather, they reflect our estimate of the cost of the procedure within the context of our cost estimation methodology for the OPPS. With the exception of services with a predetermined national payment amount, the use of a uniform scaling factor for changes in total weight between years in the ASC payment system does not alter the relativity of the OPPS payment weights as used in the ASC payment system. Differences in the relativity between the ASC relative payment weights and the OPPS relative payment weights are not driven by the application of the uniform scaling factor. The ASC weight scaling methodology is entirely consistent with the OPPS weight scaling methodology and the weights serve the same purpose in both systems, to apportion total budget neutral payment allowed under the update.

We do not agree with commenters' assertion that we should alter or eliminate the scaling methodology because the scaling factor will rarely result in an increase in ASC relative weights, therefore continuing to hurt rather than protect ASCs in the future. As we stated in the August 2, 2007 final rule (72 FR 42532), aggregate payments to ASCs could, in the absence of rescaling, be affected by changes in the cost structure of HOPDs that ought to be relevant only under the OPPS. A sudden increase in the costs of hospital outpatient emergency department or clinical 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 scaling the ASC payment weights, this change in the relative weights under the OPPS would result in a decrease in the relative weights for surgical procedures under the ASC payment system, and, therefore, a decrease in aggregate ASC payments for these same procedures. We continue to believe that changes in relative weights each year under the OPPS should not, in and of themselves, cause aggregate payments under the revised ASC payment system to increase or decrease. It is important to note that the specific adjustment factor applied in the scaling process could be positive or negative in any particular year; the fact that the scaler has not resulted in an increase to the ASC payment weights in any given year or series of years does not mean the same trend will continue, nor does it mean that the principle of preventing the ASC payment weights from being affected by fluctuations in the OPPS payment weights is inherently flawed.

As stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68754), with respect to the use of "as needed" in the text of § 416.171(e)(2) that commenters have interpreted to mean that CMS has the authority to suspend scaling the relative payment weights if it determines there is not a need to do so, the phrase does not mean that CMS will determine whether or not to adjust for budget neutrality. Rather, it means that CMS adjusts the relative payment weights as needed to ensure budget neutrality. Therefore, we do not agree with the commenters' assertion that we are under no legal obligation to continue to apply a scaling factor. If we were not to scale the ASC relative payment weights, we estimate that the CY 2011 revisions would not be budget neutral.

We agree that there are differences between the service volume estimates CMS used to establish budget neutrality based on CY 2006 claims data and those reflected in the CY 2009 claims data. In the final regulations implementing the revised ASC payment system, we made our best actuarial estimate to ensure budget neutrality. We did not intend to revisit the actuarial budget neutrality regardless of whether it could be determined that there was a difference between actual experience and our underlying data assumptions and regardless of whether or not any difference that could be determined resulted in increased or decreased expenditures under the revised ASC payment system.

Establishing budget neutrality under the OPPS does not result in budget neutrality under the revised ASC payment system; it is only to maintain budget neutrality under the OPPS. Scaling the ASC relative payment weights is an integral and separate process for maintaining budget neutrality under the ASC prospective payment system. Scaling is the budget neutrality adjustment that ensures that changes in the relative weights do not, in and of themselves, change aggregate payment to ASCs. It ensures a specific amount of payment for ASCs in any given year. Without scaling, total ASC payment could increase or decrease relative to changes in hospital outpatient payment.

We do not agree with the commenters' assertion that the ASC scaler should not reclaim dollars from the ASC payment system because, according to the commenters, there also has been real cost growth for the surgical services provided in ASCs. Although the commenters believe that scaling prevents increases in ASC spending that may be appropriate because ASC costs have increased over time, increases in cost in a prospective payment system are handled by the update factor. In a budget neutral system, we remove the independent effects of increases or decreases in payments as a result of changes in the relative payment weights or the wage indices and constrain increases to the allowed update factor. Therefore, changes in aggregate ASC expenditures related to payment rates should be determined by the update to the ASC conversion factor, the CPI–U.

For this final rule with comment period, we used our proposed methodology described above to calculate the scaler adjustment using updated ASC claims data. The final CY 2011 scaler adjustment for the first fully implemented year of the revised ASC payment system is 0.9238. This scaler

adjustment is necessary to budget neutralize the difference in aggregate ASC payments calculated using the CY 2010 ASC transitional (75/25 blend) relative payment weights and the CY 2011 fully implemented relative payment weights. We calculated the difference in aggregate payments due to the change in relative payment weights (including drugs and biologicals) holding constant the ASC conversion factor, the most recent CY 2009 ASC utilization from our claims data, and the CY 2010 wage index values. For this final CY 2011 calculation, we used the CY 2010 ASC conversion factor updated by the CY 2011 CPI–U, which is estimated as 1.5 percent, less the multifactor productivity adjustment of 1.3 percent, as discussed in section XV.H.2.b. of this final rule with comment period.

After consideration of the public comments we received, we are finalizing our CY 2010 ASC relative payment weight scaling methodology, without modification. The final CY 2011 ASC payment weight scaler is 0.9238.

b. Updating the ASC Conversion Factor

Under the OPPS, we typically apply a budget neutrality adjustment for provider level changes, most notably a change in the wage index values for the upcoming year, to the conversion factor. Consistent with our final ASC payment policy, for the CY 2011 ASC payment system, in the CY 2011 OPPS/ASC proposed rule (75 FR 46358), we proposed to calculate and apply the pre-floor and pre-reclassified hospital wage indices that are used for ASC payment adjustment to the ASC conversion factor, just as the OPPS wage index adjustment is calculated and applied to the OPPS conversion factor (73 FR 41539). For CY 2011, we calculated this proposed adjustment for the ASC payment system by using the most recent CY 2009 claims data available and estimating the difference in total payment that would be created by introducing the CY 2011 pre-floor and pre-reclassified hospital wage indices. Specifically, holding CY 2009 ASC utilization and service-mix and CY 2010 national payment rates after application of the weight scaler constant, we calculated the total adjusted payment using the CY 2011 pre-floor and pre-reclassified hospital wage indices and the total adjusted payment using the proposed CY 2011 pre-floor and pre-reclassified hospital wage indices. We used the 50-percent labor-related share for both total adjusted payment calculations. We then compared the total adjusted payment calculated with the CY 2010 pre-floor and pre-reclassified hospital wage indices to the total adjusted payment calculated with the proposed CY 2011 pre-floor and pre-reclassified hospital wage indices and applied the resulting ratio of 1.0006 (the proposed CY 2011 ASC wage index budget neutrality adjustment) to the CY 2010 ASC conversion factor to calculate the proposed CY 2011 ASC conversion factor.

Section 1833(i)(2)(C)(i) of the Act requires that, if the Secretary has not updated the ASC payment amounts in a calendar year, the payment amounts "shall be increased by the percentage increase in the 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." Because the Secretary does update the ASC payment amounts annually, we adopted a policy, which we codified at § 416.171(a)(2)(ii), to update the ASC conversion factor using the CPI–U for CY 2010 and subsequent calendar years. Therefore, the annual update to the ASC payment system is the CPI–U (referred to as the CPI–U update factor). Section 3401(k) of the Affordable Care Act amends section 1833(i)(2)(D) of the Act by adding a new clause (v) which requires that "any annual update under [the ASC payment] system for the year [after application of any reduction in any update for failure to report on quality measures, if the Secretary implements a quality reporting program for ASCs] shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)" (which we refer to as the MFP adjustment) effective with the calendar year beginning January 1, 2011. Section 3401(k) of the Affordable Care Act states that application of the MFP adjustment to the ASC payment system may result in the update to the ASC payment system being less than zero for a year and may result in payment rates under the ASC payment system for a year being less than such payment rates for the preceding year. In the CY 2011 OPPS/ASC proposed rule (75 FR 46359), we proposed to revise § 416.160 and § 416.171 to reflect this provision of the Affordable Care Act.

In accordance with section 1833(i)(2)(C)(i) of the Act, before applying the MFP adjustment, the Secretary first determines the "percentage increase" in the CPI–U, which we interpret cannot be a negative number. Thus, in the instance where the percentage change in the CPI–U for a year is negative, in the CY 2011 OPPS/ASC proposed rule (75 FR 46359), we proposed to hold the CPI–U update factor for the ASC payment system to zero. Section 1833(i)(2)(D)(v) of the Act, as added by section 3401(k) of the Affordable Care Act, then requires that the Secretary reduce the CPI–U update factor (which would be held to zero if the CPI–U percentage change is negative) by the MFP adjustment, and states that application of the MFP adjustment may reduce this percentage change below zero. If the application of the MFP adjustment to the CPI–U percentage increase would result in a MFP-adjusted CPI–U update factor that is less than zero, then the annual update to the ASC payment rates would be negative and payments would decrease relative to the prior year.

Table 54 in the CY 2011 OPPS/ASC proposed rule (75 FR 46359), set out again as Table 65 below, provides illustrative examples of how the MFP adjustment would be applied to the ASC payment system. These examples show the implication of a positive CPI–U update factor with a small MFP adjustment, a positive CPI–U update factor with a large MFP adjustment, and a CPI–U update factor of zero. We discussed in greater detail the methodology for calculating the MFP adjustment for the ASC payment system and the other payment systems affected by the MFP adjustment (found in section 1886(b)(3)(B)(xi)(II) of the Act, as added by section 3401(a) of the Affordable Care Act), in the CY 2011 MPFS proposed rule. We stated that comments on the specific mathematical calculation of the MFP adjustment should be made to that proposed rule, while comments on the application of the MFP adjustment to the CPI–U update factor under the ASC payment system should be made to the CY 2011 OPPS/ASC proposed rule.

TABLE 65—MULTIFACTOR PRODUCTIVITY ADJUSTED PAYMENT UPDATE: ILLUSTRATIVE EXAMPLES

CPI–U (percent)	MFP Adjustment (percent)	MFP—Adjusted CPI–U update factor (percent)
4.0	1.3	2.7
4.0	4.7	−0.7
0.0	0.2	−0.2

Note: Numbers may not sum due to rounding.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46359), for the 12-month period ending with the midpoint of CY 2011, the Secretary estimated that the CPI–U is 1.6 percent. The Secretary estimated that the MFP adjustment is 1.6 percent. As discussed in the CY 2011 MPFS proposed rule, we proposed to reduce the CPI–U of 1.6 percent by the MFP adjustment specific to this CPI–U, resulting in an MFP-adjusted CPI–U update factor of 0 percent. Therefore, we proposed to apply to the ASC conversion factor a 0 percent MFP-adjusted update.

For CY 2011, we also proposed to adjust the CY 2010 ASC conversion factor ($41.873) by the wage adjustment for budget neutrality of 1.0006 in addition to the MFP-adjusted update factor of zero discussed above, which resulted in a proposed CY 2011 ASC conversion factor of $41.898.

Comment: As in prior years, many commenters requested that CMS adopt the hospital market basket to update the ASC payment system. They explained that not only is the CPI–U lower than the hospital market basket but it is not appropriate for updating health care providers because, unlike the hospital market basket which analyzes hospital spending, the CPI–U is designed to capture household spending. The commenters stated that, in the most recent years, the CPI–U has been dominated by energy and housing costs rather than healthcare provider spending, and that the goods and services provided by ASCs are very similar to those provided by hospitals. Further, the commenters stated CMS uses different proxies for price increases for most of the categories of goods and services in the market basket, and provided the example of the hospital market basket being assigned a combined weight of 2.84 percent to food products, while the CPI–U assigns a weight of 14.914 percent to all food and beverages. According to commenters, the disparity in weights illustrates the inherently different cost pressures faced by the typical U.S. household and the hospital sector. The commenters also argued that the CPI–U is a poor proxy of ASC cost inflation, noting that the CPI–U has faced criticism from independent researchers and economists, who indicate, according to the commenters, that the CPI–U consistently underestimates the rate of inflation. One commenter noted that several sources forecast different CPI–U rates, suggesting that it does not make sense to use the CPI–U as the ASC update factor. The commenters argued that the difference between the ASC and OPPS conversion factors is not due to real differences in the growth of costs of goods and services furnished by ASCs and HOPDs and should not be perpetuated if the ASC payment system is to remain tied to the OPPS. The commenters asserted that CMS has the authority to use an alternative update mechanism, and believe CMS should adopt the hospital market basket as the update for the ASC payment system. The commenters stated that adopting the hospital market basket would minimize the divergence in CY 2011 payment between the ASC payment system and the OPPS and prevent the update from causing further divergence when the productivity adjustment is applied to both settings in the future.

As mentioned previously in section XV.G. of this final rule with comment period, MedPAC commented that ASCs should be required to submit cost and quality data, concurrent with a 0.6 percent increase in ASC payment rates for CY 2011, arguing that ASC cost data are needed to examine whether an existing input price index is an appropriate proxy for the costs of ASCs or whether an ASC-specific market basket should be developed.

Response: We understand the commenters' concerns regarding the update to the conversion factor for CY 2011, but note that we did not propose to change the conversion factor update methodology. We refer readers to the discussion in the August 2, 2007 final rule on this issue (72 FR 42518 through 42519).

After consideration of the public comments we received, we are generally applying our established methodology for determining the final CY 2011 ASC conversion factor. However, the methodology for determining the conversion factor now includes the MFP adjustment and we are finalizing the methodology for applying the MFP adjustment to the CPI–U update factor as proposed and discussed above. (In the CY 2011 MPFS final rule with comment period, we responded to public comments and finalized the methodology for calculating the MFP adjustment. For CY 2011, the MFP adjustment is 1.3 percent.) Using more complete CY 2009 data for this final rule with comment period than was available for the proposed rule, we calculated a wage index budget neutrality adjustment of 0.9996. Based on updated data, the CPI–U for the 12-month period ending with the midpoint of CY 2011 is now estimated to be 1.5 percent, while the MFP adjustment is 1.3 percent, resulting in an MFP-adjusted CPI update factor of 0.2 percent. The final ASC conversion factor of $41.939 is the product of the CY 2010 conversion factor of $41.873 multiplied by the wage index budget neutrality adjustment of 0.9996 and the MFP-adjusted CPI–U payment update of 0.2 percent. We note that we have factored into our budget neutrality calculations the price change resulting from the expiration of the current NTIOL class in February 2011, as discussed in section XV.E. of this final rule with comment period. As a result of the expiration of this NTIOL class, the $50 add-on payment will no longer apply in CY 2011 after February. We also note that we have not factored in the budget neutrality calculations increased spending for the new pass-through device category described by HCPCS code C1749, because it is unclear how quickly this new technology will be adopted by ASCs. We will closely monitor utilization of this device and the financial impact during CY 2011 in order to propose any appropriate budget neutrality adjustment for CY 2012.

We also are finalizing our proposal, without modification, to revise § 416.160 and § 416.171 of the

regulations to reflect section 3401(k) of the Affordable Care Act.

3. Display of CY 2011 ASC Payment Rates

Addenda AA and BB to this CY 2011 final rule with comment period display the updated ASC payment rates for CY 2011 for covered surgical procedures and covered ancillary services, respectively. These addenda contain several types of information related to the CY 2011 payment rates. Specifically, in Addendum AA, a "Y" in the column titled "Subject to Multiple Procedure Discounting" indicates that the surgical procedure will be subject to the multiple procedure payment reduction policy. As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66829 through 66830), most covered surgical procedures are subject to a 50-percent reduction in the ASC payment for the lower-paying procedure when more than one procedure is performed in a single operative session. Display of the comment indicator "CH" in the column titled "Comment Indicator" indicates a change in payment policy for the item or service, including identifying discontinued HCPCS codes, designating items or services newly payable under the ASC payment system, and identifying items or services with changes in the ASC payment indicator for CY 2011. Display of the comment indicator "NI" in the column titled "Comment Indicator" indicates that the code is new (or substantially revised) and that the payment indicator assignment is an interim assignment that is open to comment on the final rule with comment period.

The values displayed in the column titled "CY 2011 Payment Weight" are the relative payment weights for each of the listed services for CY 2011. The payment weights for all covered surgical procedures and covered ancillary services whose ASC payment rates are based on OPPS relative payment weights are scaled for budget neutrality. Thus, scaling was not applied to the device portion of the device intensive procedures, services that are paid at the MPFS nonfacility PE RVU amount, separately payable covered ancillary services that have a predetermined national payment amount, such as drugs and biologicals that are separately paid under the OPPS, or services that are contractor-priced or paid at reasonable cost in ASCs.

To derive the CY 2011 payment rate displayed in the "CY 2011 Payment" column, each ASC payment weight in the "CY 2011 Payment Weight" column is multiplied by the CY 2011 conversion factor of $41.939. The conversion factor includes a budget neutrality adjustment for changes in the wage index values and the CPI–U update factor as reduced by the productivity adjustment (as discussed in section XV.H.2.b. of this final rule with comment period).

In Addendum BB, there are no relative payment weights displayed in the "CY 2011 Payment Weight" column for items and services with predetermined national payment amounts, such as separately payable drugs and biologicals. The "CY 2011 Payment" column displays the CY 2011 national unadjusted ASC payment rates for all items and services. The CY 2011 ASC payment rates listed in Addendum AA for separately payable drugs and biologicals are based on ASP data used for payment in physicians' offices in October 2010.

We did not receive any public comments regarding the continuation of our policy to provide CY 2011 ASC payment information as detailed in Addenda AA and BB. Therefore, Addenda AA and BB to this final rule with comment period display the updated ASC payment rates for CY 2011 for covered surgical procedures and covered ancillary services, respectively, and provide additional information related to the CY 2011 rates.

XVI. Reporting Quality Data for Annual Payment Rate Updates

A. Background

1. Overview

CMS has implemented quality measure reporting programs for multiple settings of care. These programs promote higher quality, more efficient health care for Medicare beneficiaries. The quality data reporting program for hospital outpatient care, known as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), has been generally modeled after the quality data reporting program for hospital inpatient services (referred to as the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program in the proposed rule and now referred to as the Hospital Inpatient Quality Reporting Program). Both of these quality reporting programs for hospital services, as well as the program for physicians and other eligible professionals, known as the Physician Quality Reporting Initiative (PQRI), have financial incentives for the reporting of quality data to CMS. CMS also has implemented quality reporting programs for home health agencies and skilled nursing facilities that are based on conditions of participation, and an end-stage renal disease quality reporting program that is based on conditions for coverage.

2. Hospital Outpatient Quality Data Reporting Under Section 109(a) of MIEA–TRHCA

Section 109(a) of the MIEA–TRHCA (Pub. L. 109–432) amended section 1833(t) of the Act by adding a new paragraph (17) which affects the annual payment update factor applicable to OPPS payments for services furnished by hospitals in outpatient settings on or after January 1, 2009. Section 1833(t)(17)(A) of the Act states that subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Act) that fail to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act will incur a 2.0 percentage point reduction to their annual payment update factor. Section 1833(t)(17)(B) of the Act requires that hospitals submit quality data in a form and manner, and at a time, that the Secretary specifies. Section 1833(t)(17)(A)(ii) of the Act specifies that any reduction would apply only to the payment year involved and would not be taken into account in computing the applicable annual payment update factor for a subsequent payment year.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. The National Quality Forum (NQF) is a voluntary consensus standard setting organization that is composed of a diverse representation of consumer, purchaser, provider, academic, clinical, and other health care stakeholder organizations. NQF was established to standardize health care quality measurement and reporting through its consensus development process. We generally prefer to adopt NQF-endorsed measures for CMS quality reporting programs. However, we believe that consensus among affected parties also can be reflected by other means, including: Consensus achieved during the measure development process; consensus shown through broad acceptance and use of measures; and consensus through public comment. We also note that section 1833(t)(17) of the Act does not require that each measure we adopt for the HOP QDRP be endorsed by a national

consensus building entity, or by the NQF specifically.

Section 1833(t)(17)(C)(ii) of the Act allows the Secretary to "[select] measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1886(b)(3)(B)(viii)" of the Act (the Hospital Inpatient Quality Reporting Program). As we stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68758 through 68759), we do not believe that we should, without further analysis, adopt the Hospital Inpatient Quality Reporting Program measures as the measures for the HOP QDRP. We continue to believe that it is most appropriate and desirable to adopt measures that specifically apply to the hospital outpatient setting for the HOP QDRP.

Section 1833(t)(17)(D) of the Act gives the Secretary the authority to replace measures or indicators as appropriate, such as when all hospitals are effectively in compliance or when the measures or indicators have been subsequently shown not to represent the best clinical practice. Section 1833(t)(17)(E) of the Act requires the Secretary to establish procedures for making data submitted under the HOP QDRP available to the public. Such procedures include providing hospitals with the opportunity to review their data before these data are released to the public.

Comment: A few commenters appreciated CMS's acknowledgement of the consensus-based process and supported CMS's movement toward a consistent goal in using consensus-based measures that are endorsed by the NQF or other entities. Some commenters recommended that CMS only adopt measures that are NQF-endorsed and HQA-adopted in order to maintain consistency in the selection processes for quality measures across physician and hospital services. Commenters encouraged CMS to continue to work with the NQF to harmonize measures and measure specifications. Commenters believed that both the HQA and the NQF can help to identify and prioritize measures that have an important linkage to improved clinical outcomes with minimal unintended consequences. Many commenters indicated that they prefer that measures adopted for the HOP QDRP go through the rigorous, consensus-based assessment processes of both the NQF and HQA. Other commenters indicated that although a consensus-based process may have been used by CMS to develop measures, that process is not parallel to the rigorous process that precedes an NQF endorsement or an HQA adoption of a measure. One commenter was very pleased that all of the measures that were conditionally approved by the HQA Principals in March 2010 are being considered for future implementation.

Response: We thank the commenters for their support and suggestions. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to "develop measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities." This provision does not require that the measures we adopt for the HOP QDRP be endorsed by any particular entity, and we believe that consensus among affected parties can be achieved by means other than endorsement by a national consensus building entity, including through the measure development process, through broad acceptance and use of the measure(s), and through public comment. Nevertheless, we have stated on numerous occasions that we prefer to adopt quality measures that have been endorsed by the NQF because the NQF uses a formal consensus development process and has been recognized as a voluntary consensus standards-setting organization as defined by the National Technology Transfer and Advancement Act of 1995 (NTTAA) and Office of Management and Budget Circular A 119 (*see http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx*). Moreover, when we propose and adopt quality measures, we take into consideration the measures adopted by the HQA as well as an array of input from the public. The HQA is a public-private collaboration that works to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care. We appreciate HQA's integral efforts to improve hospital quality of care by supporting our public reporting programs.

Comment: One commenter applauded the decision to not automatically adopt the Hospital Inpatient Quality Reporting Program measures for the HOP QDRP without analysis for appropriateness. One commenter stated that some of the proposed chart-abstracted measures for CYs 2012 and 2013 are found in both the Hospital Inpatient Quality Reporting Program and the HOP QDRP and requested limiting the implementation to either the hospital inpatient or outpatient setting only.

Response: We thank the commenters for the support and recommendations. Some of the inpatient quality measures (for example, Aspirin at Arrival for AMI patients, Timing of Antibiotic Prophylaxis for Surgical Patients, and Antibiotic Selection for Surgical Patients) are also appropriate for the hospital outpatient setting because they address important care processes that are provided in both settings and allow us to compare the quality of care a patient is receiving in both settings. However, we continue to believe that it is also appropriate and desirable to adopt for the HOP QDRP measures that have been specifically developed for application only in the hospital outpatient setting because hospital outpatient settings present unique challenges in the operational and clinical aspects of care (for example, differences in the types of interventions, treatments, services and clinical level of care).

Comment: One commenter urged CMS to consider in its measure selection process for the HOP QDRP whether valid clinical studies support the use of the measure.

Response: In section XVI.B.1. of the proposed rule and this final rule with comment period, we describe the considerations we take into account when selecting measures to add to the HOP QDRP measure set. As part of this process, we review current science and clinical guidelines to determine whether the measure is appropriate for data collection under the HOP QDRP.

3. ASC Quality Data Reporting Under Section 109(b) of MIEA–TRHCA

Section 109(b) of the MIEA–TRHCA amended section 1833(i) of the Act by redesignating clause (iv) as clause (v) and adding new clause (iv) to paragraph (2)(D) and by adding new paragraph (7). Section 1833(i)(2)(D)(iv) of the Act authorizes, but does not require, the Secretary to implement the revised ASC payment system "so as to provide for a reduction in any annual update for failure to report on quality measures" beginning with payment for ASC services furnished on or after January 1, 2009.

Section 1833(i)(7)(A) of the Act states that the Secretary may provide that any ASC that fails to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(i)(7) of the Act will incur a reduction in any annual payment update of 2.0 percentage points. Section 1833(i)(7)(A) of the Act also specifies

that a reduction for one year cannot be taken into account in computing the annual ASC payment update for a subsequent year.

Section 1833(i)(7)(B) of the Act provides that, "[e]xcept as the Secretary may otherwise provide," the hospital outpatient quality data provisions of subparagraphs (B) through (E) of section 1833(t)(17) of the Act, summarized above, shall apply to ASCs in a similar manner to the manner in which they apply under these paragraphs to hospitals under the HOP QDRP. We did not implement an ASC quality reporting program for CY 2008 (72 FR 66875), for CY 2009 (73 FR 68780), or for CY 2010 (74 FR 60656).

We refer readers to section XVI.F. of this final rule with comment period for further discussion of ASC quality data reporting.

4. HOP QDRP Quality Measures for the CY 2009 Payment Determination

For the CY 2009 annual payment update, we required HOP QDRP reporting using seven quality measures—five Emergency Department (ED) Acute Myocardial Infarction (AMI) Cardiac Care measures and two Surgical Care measures. These measures address care provided to a large number of adult patients in hospital outpatient settings across a diverse set of conditions, and were selected for the initial set of HOP QDRP measures based on their relevance as a set to all HOPDs.

Specifically, for hospitals to receive their full OPPS annual payment update for services furnished in CY 2009, in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66865 and 66871), we required that subsection (d) hospitals paid under the OPPS submit data on the following seven measures for hospital outpatient services furnished on or after April 1, 2008: (1) ED–AMI–1: Aspirin at Arrival; (2) ED–AMI–2: Median Time to Fibrinolysis; (3) ED–AMI–3: Fibrinolytic Therapy Received within 30 Minutes of Arrival; (4) ED–AMI–4: Median Time to Electrocardiogram (ECG); (5) ED–AMI–5: Median Time to Transfer for Primary PCI; (6) PQRI #20: Surgical Care—Timing of Antibiotic Prophylaxis; and (7) PQRI #21: Surgical Care—Selection of Antibiotic.

5. HOP QDRP Quality Measures for the CY 2010 Payment Determination

For the CY 2010 payment update, we required continued submission of data on the existing seven measures discussed above (73 FR 68761), and adopted four new imaging measures (73 FR 68766). For CY 2010, we also changed the measure designations for the existing seven measures to an "OP-#" format. For example, the designations of ED–AMI–2 and ED–AMI–3 were changed to OP–1 and OP–2 so that the eleven measures for the CY 2010 payment update were designated as OP–1 through OP–11. This change allowed us to maintain a consistent sequential designation system that we could expand as we add additional measures.

The four imaging measures that we adopted beginning with the CY 2010 payment determination (OP–8: MRI Lumbar Spine for Low Back Pain, OP–9: Mammography Follow-up Rates, OP–10: Abdomen CT—Use of Contrast Material, and OP–11: Thorax CT—Use of Contrast Material) are claims-based measures that CMS will calculate using Medicare Part B claims data without imposing upon hospitals the burden of additional chart abstraction. For purposes of the CY 2010 payment determination, we calculated these measures using CY 2008 Medicare administrative claims data.

In the CY 2009 OPPS/ASC proposed rule, OP–10 had two submeasures listed: OP–10a: CT Abdomen—Use of contrast material excluding calculi of the kidneys, ureter, and/or urinary tract, and OP–10b: CT Abdomen—Use of contrast material for diagnosis of calculi in the kidneys, ureter, and or urinary tract. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68766), we finalized OP–10 (previously known as OP–10a): Abdomen CT—Use of Contrast Material. In the CY 2010 OPPS/ASC proposed rule and final rule with comment period (74 FR 35396 and 60631, respectively), we clarified that we are calculating OP–10 excluding patients with impaired renal functions because they are not candidates for an abdominal CT with contrast. This exclusion is described in greater detail in the *Specifications Manual for Hospital Outpatient Department Quality Measures* (HOPD Specifications Manual) located at the QualityNet Web site (*http://www.QualityNet.org*).

The complete set of 11 measures that we used for the CY 2010 payment determination is listed at 73 FR 68766.

6. HOP QDRP Quality Measures, Technical Specification Updates, and Data Publication for the CY 2011 Payment Determination

a. Quality Measures

For the CY 2011 payment determination, we required hospitals to continue to submit data on the existing 11 HOP QDRP measures. These measures continue to address areas of clinical importance regarding the quality of care provided in HOPDs, and reflect consensus among affected parties. Seven of these 11 measures are chart-abstracted measures in two areas of importance that are also measured for the inpatient setting—AMI cardiac care and surgical care. The remaining four measures address imaging efficiency in HOPDs.

For the CY 2011 payment determination, we did not add any new HOP QDRP measures. We indicated our sensitivity to the burden upon HOPDs associated with chart abstraction and stated that we seek to minimize the collection burden associated with quality measurement. We also stated that we will continue to assess whether we can collect data on additional quality measures through mechanisms other than chart abstraction, such as from Medicare administrative claims data and EHRs.

The complete set of 11 measures that will be used for the CY 2011 payment determination is listed at 74 FR 60637.

Comment: One commenter expressed appreciation for CMS's sensitivity to the burden associated with chart abstraction and CMS's desire to minimize the collection burden associated with quality reporting by not proposing new measures for the CY 2011 payment determination. Another commenter believed it is inappropriate to use measures based solely on claims data without the use of clinical records. This commenter was concerned that claims data may not portray an accurate picture of the care provided to a patient.

Response: We thank the commenter for the support of our efforts to minimize the data collection burden under the HOP QDRP. We intend to limit the burden associated with chart abstraction by proposing in the future to adopt measures for the HOP QDRP for which data can be collected via EHRs. We disagree that measures for which data are collected via Medicare FFS claims cannot provide an accurate picture of hospital quality. We believe that claims data are an appropriate source of data for the HOP QDRP. We also note that the NQF has endorsed many evidence-based quality measures that are calculated using claims and other administrative data. Furthermore, the use of claims-based measures reduces the burden on hospitals associated with chart abstraction.

We also received specific comments, discussed below, on the measures we proposed to use for the CY 2011 payment determination.

• OP–3: Median Time To Transfer to Another Facility for Acute Coronary Intervention

Comment: One commenter recommended that CMS consider measuring the overall median time to PCI in transferred patients since this captures the entire process of care and will encourage collaboration between transferring and receiving ST-segment elevation myocardial infarction (STEMI) centers.

Response: We thank the commenter for this suggestion. The current OP–3 measure assesses the quality of care provided at the initial (transferring) facility rather than at both the transferring and receiving facility. Thus, this measure focuses on how long a patient spent at hospital outpatient department from the time of he/she arrived to the time he/she departed, which is an important component of the total time to reperfusion (reperfusion in acute myocardial infarction is the process by which blocked arteries are opened to restore blood flow to the tissues). A modification to the measure as suggested would not currently be feasible to implement as it would require capturing information from medical records at two separate facilities. However, in the future, we may consider linking the required data collection on the transfer of patients for PCI including arrival time at the transferring hospital and PCI time at the receiving hospital.

• OP–4: Aspirin at Arrival & OP–5: Median Time to ECG

Comment: One commenter noted that the OP–4: Aspirin at Arrival measure has the potential to become "topped out" as the program matures. The commenter encouraged CMS to work with the measure developer to determine at which point it may be appropriate for this measure to be retired. One commenter requested that CMS consider adding patient exclusion criteria to the OP–4 and OP–5 AMI/Chest Pain measures (ASA at arrival and Median Time to EKG). The commenter noted that patients with chest pain Not Elsewhere Classified (NEC) are not probable cardiac cases and recommended that patients in the observation units should be excluded as well.

Response: We thank the commenters for the input and we will evaluate the continued utility of OP–4 over time as we do with all measures that we have adopted for the HOP QDRP. We disagree with the commenter's suggestion that we exclude patients with chest pain NEC in the measure population because the diagnosis codes assigned after evaluation of the patient may not reflect the unknown nature of chest pain when a patient initially presents at the ED. However, patients are excluded from the measure population if there is sufficient documentation that the focus of care was non-cardiac. Additionally, patients placed in observation units and later transferred to a facility are included in the measure population to assess how timely they are receiving care.

• OP–6: Timing of Antibiotic Prophylaxis & OP–7: Prophylactic Antibiotic Selection for Surgical Patients

Comment: One commenter disagreed with the patient inclusion and exclusion criteria of the OP–6 measure in the HOP QDRP measure set, and noted that it is inappropriate and burdensome to implement the OP–6 measure, and urged CMS to reassess the utility of this measure. The commenter recommended replacing the current OP–6 and OP–7 measures with the "Timing of Antibiotic Prophylaxis and Prophylactic Antibiotic Selection for Surgical Patient" measures developed by the ASC Quality Collaboration.

One commenter requested that CMS consider including in the measure specifications one or more oral alternatives to ciprofloxacin for transrectal prostate biopsy antibiotic prophylaxis. This commenter believed that second generation oral cephalosporins offer the adequate bioavailability and pathogen spectrum in situations where ciprofloxacin may not be optimal or if local epidemiology indicates that there is an increased rate of ciprofloxacin-resistant enteric gram-negative pathogens in the community. The commenter stated that third generation oral cephalosporins would be reasonable as well.

One commenter believed that OP–7 is appropriate only for physician reporting.

Response: The OP–6 measure is designed to assess whether hospital outpatient departments administer prophylactic antibiotics immediately before the surgical incision takes place which has been shown to decrease the likelihood of surgical site infections, rather than hours before (which has been shown to increase the likelihood of surgical site infections). We do not believe that it is overly burdensome for hospital outpatient departments to report data on this measure because the measure only applies to operations for which antibiotics are always recommended in various clinical guidelines. We also note that the OP–6 measure has been used in the inpatient setting for quality reporting since July 2006. While there may be controversy about whether an antibiotic should be started, at most, 30 minutes before the incision is made, or from 30–59 minutes before the incision is made, there is little controversy in multiple published studies that the rate of surgical site infections increases for each hour that an antibiotic is not administered before a surgical incision is made. We thank the commenters for their suggested alternative measures and alternative antibiotics to include in the measure. We believe that optimal antibiotic prophylaxis with respect to timing and selection ensures that there will be adequate concentrations of an antimicrobial in the serum, tissue, and wound while the incision is open and, therefore, affects the quality of care. With respect to the commenter's suggestion regarding oral alternatives to ciprofloxacin, we note that we have examined this issue, including raising it with a technical expert panel that we convened for the purpose of advising CMS on the development and maintenance of quality measures. This panel is comprised of interested stakeholders, including hospital representatives, payers, practitioners from various medical specialties, consumers, and clinical, scientific, and performance measurement experts. After examining the issue, we concluded that fluoroquinolones should be the only oral antibiotics included in the measure specifications. The infections that occur after prostate biopsy are soft tissue infections (not urinary tract infections) and, therefore, urinary concentrations of antibiotics are not relevant. Hospitals may report their use of first and second generation cephalosporins under the measure specifications, but the specifications say that these antibiotics must be administered intravenously as there are no studies of sufficient validity showing the efficacy of these agents orally for prostate biopsy.

With regard to the comment on the appropriateness of reporting OP–7 at only a physician level, we note that this quality measure assesses the appropriate selection of antibiotics for patients having surgery performed in a hospital outpatient department and mirrors the SCIP Infection 2 quality measure that we have adopted for the Hospital Inpatient Quality Reporting program. We also note that the measure is based on published guidelines for surgical antimicrobial prophylaxis, and we believe that it is appropriate for a hospital outpatient department to report

whether its patients are receiving care consistent with these guidelines.

• Imaging Efficiency Measures

We received the following comments on the imaging efficiency measures that we are including in the HOP QDRP measure set for CY 2011:

Comment: Many commenters objected to our adoption of the four imaging efficiency measures into the HOP QDRP CY 2011 measure set. Many of these commenters objected because none of the four measures have been adopted by the HQA and only two are NQF-endorsed. Commenters stated that the two non-NQF-endorsed measures: "OP–10 Use of Contrast: Abdomen CT" and "OP–9 Mammography Follow-up Rates" are particularly inappropriate for the HOP QDRP and believed that they could also cause harm to patients. Additionally, the commenters noted that CMS' own consumer testing of the Web site display of the imaging efficiency measures suggests that healthcare consumers do not understand how to interpret these measures, and that their confusion has grown since CMS published the measure data on *Hospital Compare* in July 2010.

Response: Many of the concerns raised by the commenters about the imaging efficiency measures we adopted for the CY 2011 payment determination were also raised at the time these measures were first proposed for the CY 2010 payment determination. We responded to these concerns when we adopted the measures (73 FR 68762 through 68766). We stated that the measures meet the statutory requirement of reflecting consensus among affected parties because of their consensus-based development, and that the measures address important patient safety concerns related to exposure to unnecessary radiation and contrast materials. We also stated that the Secretary is not required to limit measures considered for HOP QDRP adoption only to those adopted by the HQA or endorsed by the NQF. Regarding whether there is consumer understanding of the measures, we engage in extensive consumer testing to ensure that each measure is meaningful to and understandable by consumers. If we are made aware that the way a measure is publicly reported is confusing to consumers, we work to revise the descriptive information made available on the measure. Experience has also shown that as the public becomes more familiar with measure reporting, their understanding regarding how to interpret and use the information improves. Additionally, on the *Hospital Compare* Web site, in the "Learn more * * * " section of the Compare page, we explain that consumers should "Talk with your doctor about the results shown here and what a facility's results mean for you and your care."

Comment: Two commenters stated that the terminology used on *Hospital Compare* to explain the quality data to the public may be misleading or have negative connotations, which could have unintended consequences such as potentially alarming patients and the public. As an example, the commenters stated that the use of the term "double scan" to explain OP–10 (Abdomen CT—Use of Contrast Material) and OP–11 (Thorax CT—Use of Contrast Material) to the public may create a false impression that these exams are always unnecessarily duplicative. The commenters supported these measures and believed that they have the potential to reduce unnecessary imaging, however they stated that there are instances when combination with and without contrast exams provide necessary and valuable information about abnormalities, many of which are cancers, and many of which could not be adequately diagnosed without pre- and post-contrast scanning.

Response: We recognize the commenters' concerns and agree that the terminology used on the *Hospital Compare* Web site should convey enough information so that the public can make informed decisions regarding their healthcares. We also appreciate the commenters' drawing particular attention to the use of the term "double scan," and we will revisit whether the use of this term on the *Hospital Compare* Web site is appropriate.

We further agree that there are instances when combination CT studies may be appropriate for the diagnosis of certain conditions, and that such studies may provide essential medical information. The imaging efficiency measures we have adopted for the CY 2011 payment determination use three specific CPT codes that indicate that the study is a combined study: without contrast, with contrast, and with and without contrast (combined study). In developing these imaging efficiency measures, we completed an extensive review of the relevant literature and medical guidelines and criteria, and worked closely with a technical expert panel we convened for the purposes of making recommendations regarding which conditions, for example certain cancers in the case of CT abdomen, should be excluded from the calculation of these measures. We will revisit whether such exclusions should be explained on the Web site in order to provide more context to consumers about appropriateness of combined studies in these instances. We note that on the *Hospital Compare* Web site there is a specific link, "Learn more about the use of medical imaging tests and why these measures are important." This section provides information about the use of contrast material, and the use of studies with and without contrast. The information provided indicates that for some parts of the body and some medical conditions, combination scans are appropriate. In addition, where the *Hospital Compare* Web site compares a hospital's ratio calculation to State and national averages, as well as to the ratio calculations of other hospitals, the purpose is not to suggest that we expect hospitals not to perform any combination studies, but rather to make hospitals that perform a high number of combination studies aware of their outlier imaging patterns.

• OP–8: MRI Lumbar Spine for Lower Back Pain

Comment: One commenter noted that the OP–8: MRI Lumbar Spine for Lower Back Pain measure is inappropriate as a hospital outpatient quality measure because it is highly likely that the information relating to services performed on a patient in the previous 60 days would not be readily available at the point of service. The commenter recommended that the measure focus on the practice of the ordering physician and not on the facility's utilization of imaging services.

Response: Hospitals routinely deal with patients for whom they may not have prior history information readily available. We are aware that there are commonly used approaches for obtaining this prior history information, such as through the use of initial forms that patients complete or quick assessment questions asked by clinical staff. For this reason, we believe that the measure is appropriate in the hospital outpatient setting.

• OP–9 Mammography Follow-Up Rates

Comment: Commenters noted that the NQF did not endorse OP–9 because of its concern that the reporting of the measure will motivate hospitals to lower their follow-up rates and, as a result, will lead to a higher number of missed cancers.

Response: We believe that this measure meets the requirement in section 1833(t)(17)(C)(i) of the Act that the Secretary develop measures appropriate for measurement of quality of care furnished by hospitals in outpatient settings that reflect

consensus among affected parties, and, to the extent feasible and practicable, that the measures include measures set forth by one or more national consensus building entities. Specifically, we convened a technical expert panel for the purpose of making recommendations to CMS regarding the development and maintenance of the imaging efficiency measures, including OP–9, which we adopted for the HOP QDRP CY 2011 payment determination. This technical expert panel was comprised of interested stakeholders, including hospital representatives, payers, practitioners from various medical specialties, consumers, and clinical, scientific, and performance measurement experts. In addition, we solicited informal public comment on the measures and measure specifications, which was used to refine the measures. We are very interested in continuing its work on mammography imaging measures and intend to pursue the feasibility of also developing a cancer detection rate measure.

We do not believe that the measure encourages HOPDs to reduce appropriate mammography follow-up study. The mammography follow-up rate measure was developed through an extensive process that included review by a technical expert panel convened by CMS. The measure assesses an HOPD's rate of "call-backs" from indeterminate or inadequate mammography screening studies.

We want to emphasize that the measure looks at the entire spectrum in terms of call-backs. Specifically, we are concerned not only with rates that seem higher than the majority of HOPDs, but also with rates that seem too low, which could possibly be indicative of inadequate cancer detection processes. We emphasize that we are concerned with both of these considerations.

b. Maintenance of Technical Specifications for Quality Measures

Technical specifications for each HOP QDRP measure are listed in the *HOPD Specifications Manual,* which is posted on the CMS QualityNet Web site at *http://www.QualityNet.org.* We maintain the technical specifications for the measures by updating this HOPD Specifications Manual and including detailed instructions and calculation algorithms. In some cases where the specifications are available elsewhere, we may include links to Web sites hosting technical specifications. These resources are for hospitals to use when collecting and submitting data on required measures.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68766 through 68767), we established a subregulatory process for updates to the technical specifications that we use to calculate HOP QDRP measures. This process is used when changes to the measure specifications are necessary due to changes in scientific evidence or in the measure as endorsed by the consensus entity. Changes of this nature may not coincide with the timing of our regulatory actions, but nevertheless require inclusion in the measure specifications so that the HOP QDRP measures are calculated based on the most up-to-date scientific and consensus standards. We indicated that notification of changes to the measure specifications on the QualityNet Web site, *http://www.QualityNet.org,* and in the HOPD Specifications Manual that occurred as a result of changes in scientific evidence or national consensus would occur no less than 3 months before any changes become effective for purposes of reporting under the HOP QDRP.

The HOPD Specifications Manual is released every 6 months and addenda are released as necessary providing at least 3 months of advance notice for insubstantial changes such as changes to ICD–9, CPT, NUBC, and HCPCS codes, and at least 6 months notice for substantive changes to data elements that would require significant systems changes.

Comment: One commenter stated that frequently, there are significant differences in the technical specifications for measures endorsed by the NQF and the technical specifications for the same measures when published in the HOPD Specifications Manual. Two commenters recommended that CMS post measure specifications on QualityNet at the same time that the OPPS/ASC proposed rule is published, in order to ensure that at the time CMS proposes to adopt measures, their exact specifications and methodologies for calculation are completely publicly available. This would provide more time for hospitals to align the measure specifications with EHRs. The commenters also suggested that subsequent changes to data specifications be posted on QualityNet and notices go to providers through the *QualityNet.org* listserv notification. One commenter was pleased with the biannual (twice a year) release of the HOPD Specifications Manual update as it provided hospitals more lead time to prepare for compliance.

Response: We strive to make the measure specifications publicly available at the time the measures are proposed for the HOP QDRP. However, at the time many measures are proposed, the specifications are still in draft form, and we believe that posting them before they have been finalized could cause confusion. Where this is the case, we strive to provide detailed descriptions of the proposed measures so that the public can submit informed comments. As soon as the specifications are finalized, we post them on *QualityNet.org.* Revisions to data specifications are also posted on QualityNet along with a Release Notes document that provides each change along with the rationale for the change.

We recognize that measure maintenance is a continuous and dynamic process. Therefore, to the extent that we want to modify the technical specifications for an NQF-endorsed measure that we have adopted for the HOP QDRP, we cannot always secure a completed NQF review of the modifications prior to the times we need to make them. However, we submit any modifications we choose to make to an NQF-endorsed measure to the NQF for review as part of the regular measure re-evaluation process conducted by the NQF. We welcome specific information that would identify where significant differences exist in measure specifications between CMS and the NQF for what is meant to be the same measure. This would permit CMS and the NQF to reconcile significant inconsistencies that should not exist.

c. Publication of HOP QDRP Data

Section 1833(t)(17)(E) of the Act requires that the Secretary establish procedures to make data collected under the HOP QDRP program available to the public. It also states that such procedures must ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. To meet these requirements, data that a hospital has submitted for the HOP QDRP are typically displayed on CMS Web sites such as the *Hospital Compare* Web site, *http://www.hospitalcompare.hhs.gov* after a preview period. The *Hospital Compare* Web site is an interactive Web tool that assists beneficiaries by providing information on hospital quality of care. This information encourages beneficiaries to work with their doctors and hospitals to discuss the quality of care hospitals provide to patients, thereby providing an additional incentive to hospitals to improve the quality of care that they furnish.

In general, we strive to display hospital quality measures on the *Hospital Compare* Web site as soon as

possible after they have been adopted and are available to CMS for reporting. However, if there are unresolved display issues or pending design considerations, we may make the data available on other non-interactive CMS Web sites such as *http://www.cms.hhs.gov/HospitalQualityInits/*. Publicly reporting the information in this manner, though not on the *Hospital Compare* Web site, allows CMS to meet the requirement under section 1833(t)(17)(E) of the Act for establishing procedures to make quality data submitted available to the public following a preview period. We proposed that, under circumstances when we display hospital quality information on non-interactive CMS Web sites for reasons discussed earlier, affected parties would be notified via CMS listservs, CMS e-mail blasts, national provider calls, and QualityNet announcements regarding the release of preview reports followed by the posting of data on a Web site other than *Hospital Compare* (75 FR 46362). The release of preview reports allows CMS to meet the requirement under section 1833(t)(17)(E) of the Act for establishing procedures to make submitted quality data available to the public following a preview period. CMS also requires hospitals to complete and submit a registration form ("participation form") in order to participate in the HOP QDRP. With submission of this form, participating hospitals agree that they will allow CMS to publicly report the quality measures, including those that CMS calculates using Medicare claims, as required by the Act and the HOP QDRP.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68778), we established that, for CY 2010, hospitals sharing the same CMS Certification Number (CCN, previously known as the Medicare Provider Number (MPN)) must combine data collection and submission across their multiple campuses for the clinical measures for public reporting purposes. We finalized the policy that, under the HOP QDRP, we will publish quality data by the corresponding CCN. This approach is consistent with the approach taken under the Hospital Inpatient Quality Reporting Program. In the CY 2009 OPPS/ASC final rule with comment period, we also stated that we intend to indicate instances where data from two or more hospitals are combined to form the publicly reported measures on the Web site.

In the CY 2010 OPPS/ASC final rule with comment period, we finalized our CY 2010 policy regarding publication of HOP QDRP data (74 FR 60652 through 60654). Section 1833(t)(17)(E) of the Act requires that the Secretary establish procedures to make data collected under the HOP QDRP available to the public; however, this section does not require that such data be validated before it is made public. We explained that, initially, we decided not to post "[i]nformation from non-validated data, including the initial reporting period (April–June 2008)" as discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66874). We noted, however, that data submitted by hospitals are publicly reported regardless of whether those data are successfully validated for payment determination purposes under existing procedures for the Hospital Inpatient Quality Reporting Program. We also noted that, in the CY 2009 OPPS/ASC final rule with comment period, we stated that we intended to make the information collected under the HOP QDRP available to the public in 2010 (73 FR 68778).

In the CY 2010 OPPS/ASC proposed rule (74 FR 35404), we proposed to make data collected for quarters beginning with the third quarter of CY 2008 (July–September 2008) under the HOP QDRP publicly available, regardless of whether those data have been validated for payment determination purposes. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60654), we finalized our proposal to publicly report HOP QDRP data on *Hospital Compare* in 2010 with some modifications in the periods of time to be reported.

Comment: Some commenters recognized and supported CMS's efforts to publicly report hospital outpatient measures on *Hospital Compare.* Other commenters argued that the data presented in the *Hospital Compare* Web site are vague and confusing to providers and beneficiaries. As an example, these commenters noted that there is no explanation of what "not available" means.

Response: We strive to make complex quality data submitted by hospitals under the HOP QDRP comprehensible and useful to a wide range of audiences including patients and providers. We agree that there is room for improvement and will continue to work toward improving the *Hospital Compare* Web site. We employ 'Not Available' to indicate that measure data for a particular hospital or hospital outpatient department is not available. CMS does not generally indicate the reason that data are not available. Situations in which measure data might not be available include:

- A hospital outpatient department has voluntarily submitted data but has chosen not to have that data made publicly available either because it opted out of the HOP QDRP program or is not a subsection (d) hospital paid under the OPPS;
- No data were reported because the hospital outpatient department does not provide the services to which the measure applies; and
- No data were reported because the hospital outpatient department provides the services to which the measure applies but had no cases.

Comment: One commenter suggested allowing the public to comment on the format of public reporting of data on *Hospital Compare,* and on proposed measures for the future prior to their implementation.

Response: We provide the public with many opportunities to submit comments on the format for the public reporting of data on *Hospital Compare,* including during the measure development process (if the measure is developed by CMS), during preliminary national "dry runs" for hospitals held prior to implementation of the measure in formal public reporting, in which we issue confidential reports with calculations and methodological information, as well as during the rulemaking process.

Comment: Commenters made several suggestions that they believed would enhance the public reporting of HOP QDRP data:

- Add a narrative to explain the impact of reporting individual measures on hospital quality of care;
- Group like measures by condition or disease, and distinguish them by care setting;
- Display volume-related measures in a manner that makes clear that they should not be equated with quality of care measures;
- Conduct consumer testing and allow multi-stakeholders to comment on changes in the *Hospital Compare* architecture, navigation, display and language that would make it more user friendly; and
- Add more notations to the terminology used.

Response: We thank the commenters for these suggestions and will consider them as we further develop our procedures for the public reporting of HOP QDRP quality data.

After consideration of the public comments we received, we have decided to finalize our proposal to use other non interactive CMS Web sites such as *http://www.cms.hhs.gov/HospitalQualityInits/* to publicly report HOP QDRP data for which there are unresolved display issues or pending design considerations. We will provide hospitals with an opportunity to

preview the data to be posted in this manner prior to doing so.

B. Expansion of HOP QDRP Quality Measures for the CY 2012, CY 2013, and CY 2014 Payment Determinations

1. Considerations in Expanding and Updating Quality Measures Under the HOP QDRP

In general, when selecting measures for the HOP QDRP program, we take into account several considerations and goals. These include: (a) Expanding the types of measures beyond process of care measures to include an increased number of outcome measures, efficiency measures, and patients' experience-of-care measures; (b) expanding the scope of hospital services to which the measures apply; (c) considering the burden on hospitals in collecting chart-abstracted data; (d) harmonizing the measures used in the HOP QDRP program with other CMS quality programs to align incentives and promote coordinated efforts to improve quality; (e) seeking to use measures based on alternative sources of data that do not require chart abstraction or that utilize data already being reported by many hospitals, such as data that hospitals report to clinical data registries, or all-payer claims data bases; and (f) weighing the relevance and utility of the measures compared to the burden on hospitals in submitting data under the HOP QDRP program.

Specifically, we assign priority to quality measures that assess performance on: (a) Conditions that result in the greatest mortality and morbidity in the Medicare population; (b) conditions that are high volume and high cost for the Medicare program; and (c) conditions for which wide cost and treatment variations have been reported, despite established clinical guidelines. We have used and continue to use these criteria to guide our decisions regarding what measures to add to the HOP QDRP measure set.

In the CY 2009 OPPS/ASC final rule with comment period, we adopted four claims-based quality measures that do not require a hospital to submit chart-abstracted clinical data (73 FR 68766). This supports our goal of expanding the measures for the HOP QDRP while minimizing the burden upon hospitals and, in particular, without significantly increasing the chart abstraction burden. In addition to claims-based measures, we are considering registries [1] and EHRs as alternative ways to collect data from hospitals. Many hospitals submit data to and participate in existing registries. In addition, registries often capture outcome information and provide ongoing quality improvement feedback to registry participants. Instead of requiring hospitals to submit the same data to CMS that they are already submitting to registries, we could collect the data directly from the registries with the permission of the hospital, thereby enabling us to expand the HOP QDRP measure set without increasing the burden of data collection for those hospitals participating in the registries. The data that we would receive from registries would be used to calculate quality measures required under the HOP QDRP, and would be publicly reported like other HOP QDRP quality measures, encouraging improvements in the quality of care. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60633), we responded to public comments on such an approach.

In the CY 2009 OPPS/ASC final rule with comment period, we also stated our intention to explore mechanisms for data submission using EHRs (73 FR 68769). We have adopted the definition of Qualified EHR set forth by the Office of the National Coordinator for Health Information Technology (ONC) (45 CFR 170.102) which has adopted the statutory definition of Qualified EHR found in section 3000(13) of the Public Health Service Act. That section defines a Qualified EHR as "an electronic record of health-related information on an individual that—(A) includes patient demographic and clinical health information, such as medical history and problem lists; and (B) has the capacity—(i) to provide clinical decision support; (ii) to support physician order entry; (iii) to capture and query information relevant to health care quality; and (iv) to exchange electronic health information with, and integrate such information from other sources."

We also have adopted the definition of Certified EHR Technology set forth by the ONC at 45 CFR 170.102 as follows: "Certified EHR Technology" means (1) a complete EHR that meets the requirements included in the definition of a Qualified EHR and has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary; or (2) a combination of EHR Modules in which each constituent EHR Module of the combination has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary, and the resultant combination also meets the requirements included in the definition of a Qualified EHR.

Establishing a data submission mechanism using EHRs system will require interoperability between EHRs and our data collection systems, additional infrastructure development on the part of hospitals and CMS, and the adoption of standards for the capturing, formatting, and transmission of data elements that make up the measures. However, once these activities are accomplished, the adoption of measures that rely on data obtained directly from EHRs would enable us to expand the HOP QDRP measure set with less cost and burden to hospitals. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60633 through 60634), we responded to public comments on such an approach.

In prior years, we have proposed measures for one payment determination in a given rulemaking cycle. In prior rules, we have identified measures for future consideration, but have not proposed or finalized measures beyond those to be collected and used for the next sequential payment determination. In the CY 2011 OPPS/ASC proposed rule (75 FR 46363), we proposed to adopt new measures over a three-year period of time for the CY 2012, CY 2013, and CY 2014 payment determinations. We believe this proposed process will assist hospitals in planning, meeting future reporting requirements, and implementing quality improvement efforts. We will also have more time to develop, align, and implement the infrastructure necessary to collect data on the measures and make payment determinations. To the extent that we finalize some or all of these measures for the CY 2012, CY 2013 and CY 2014 payment determinations, this would not preclude us from proposing to adopt additional measures or changing the list of measures for future payment determinations through subsequent rulemaking cycles that affect these future payment determinations. We invited comments on our intention to propose measures for more than one payment determination in a single rulemaking.

Comment: Several commenters were very pleased to see that some of the proposed measures have a strong focus on overuse, efficiency, care coordination and transitions, and process linking to outcomes. Several commenters stated their belief that the HOP QDRP has a positive impact on the quality of care. A commenter stated that all of the proposed quality measures reflect the National Priorities Partnership-

[1] A registry is a collection of clinical data for purposes of assessing clinical performance, quality of care, and opportunities for quality improvement.

identified goal for these areas and that these measures will provide meaningful information to consumers, purchasers, and providers.

Some commenters stated that they did not believe CMS follows a methodical framework and a clear set of criteria to prioritize and integrate measures into the HOP QDRP.

Response: We thank the commenters for the recognition of our efforts. We agree that the proposed HOP QDRP measures are important to the quality of care patients receive in the HOPD.

The National Priorities Partnership is a 28-member organization convened by the NQF for the purpose of identifying improvement goals and action steps for the U.S. healthcare system. CMS is a member of the National Priorities Partnership and participates in its framework-setting activity. Our measure selection activities and measure development activities take into account the priorities established by this organization as well as other criteria described earlier.

We strive to ensure that the HOP QDRP measure set reflects HHS priorities as well as changes in legislation. One of our goals is to align the quality measures for which hospitals submit data under various HHS programs, including the HITECH EHR Incentive Program, in order to reduce the burden on hospitals that report data to multiple programs. We also try to adopt measures for the HOP QDRP program that are broadly applicable to hospitals paid under the OPPS, because HOP QDRP measures are made publicly available in comparative reporting tools. The measures that we are adopting for the HOP QDRP in this final rule with comment period represent established HHS priorities, which include some of the priorities selected by the NQF National Priorities Partners process. These include patient safety, population health, and care coordination.

With regard to the comments about using a methodical framework and a clear set of criteria to prioritize and integrate measures into the HOP QDRP, we have set out explicit criteria that we use to guide our decisions regarding what measures to add to the HOP QDRP measure set in section XVI.B.1. of this final rule with comment period.

Comment: A few commenters felt that the burden on hospitals stemming from a simultaneous implementation of new quality reporting and pay for performance programs would be too great, and requested that CMS limit the adoption of new measures to one program at a time. In addition, commenters recommended that CMS ease the burden on hospitals by putting a moratorium on the adoption of new quality measures until hospitals have transitioned into ICD–10 codes and adopted EHRs to meet the meaningful use objectives under the HITECH EHR Incentive Program. Some commenters were very concerned about the burden of the proposed chart-abstracted measures and doubted whether the codes used in chart-abstraction will be consistently accurate.

Response: We understand the burden faced by hospitals stemming from implementing multiple technological changes including the ICD–10 coding system, as well as meeting the requirements of various quality reporting programs. We will continue to weigh the burden associated with adding chart-abstracted measures to the HOP QDRP against the benefit of adding such measures while exploring other alternative data collection mechanisms for the HOP QDRP. Nonetheless, we are committed to broadening the scope of the HOP QDRP and, therefore, are adopting additional measures in this final rule with comment period. We also have solicited comments on measures being considered for adoption in future years.

Comment: Commenters submitted some suggestions to make the HOP QDRP measure development process more transparent in the future:

- Analysis for the need of the measure
- Risk-adjustment methodology
- Name of the developer of the measure
- Name of the organization that field-tested the measure
- Field testing status of the measure and its readiness for inclusion in a quality reporting program
- Identification of unintended consequences
- HQA adoption and NQF-endorsed status
- CMS collaboration with the Centers for Disease Control and Prevention (CDC) and the Agency for Healthcare Research and Quality (AHRQ)
- Adopt related evidence-based practice guidelines
- Clearly define the patient population for which the measure would apply
- Detailed measure specifications
- Describe clearly the impact of the measure on hospital quality
- A robust feedback loop to ascertain issues identified during implementation that would necessitate a change to a measure
- Describe the time-frame for any time-based measures
- Provide the rationale for inclusion of a proposed measure in the HOP QDRP instead of as an meaningful use objective under the HITECH rule
- Location of the measure data elements in an EHR

Response: We thank the commenters for these suggestions. We provide detailed information on each measure we adopt for the HOP QDRP at the time that we propose it or as soon as it becomes available. However, some of the suggested information, including the identification of unintended consequences and the measure's impact on hospital quality, may not be available until after we have adopted the measure. We also believe that our measure development process is transparent as it includes an extensive review of current guidelines and peer-reviewed literature, as well as collaboration with a technical expert panel. Additionally, in instances when there is uncertainty about the appropriateness of a measure for a particular patient population, the patients are treated as "exclusions" (that is, they are not included in the measurement calculation). The public has the opportunity to comment on measures that we develop during the measure development process. Additionally, the measure specifications, including the methodology used to calculate the measures, are made publicly available as soon as they are finalized either in the HOPD Specifications Manual on an "informational" basis, or on a separate Web site such as *http://www.imagingmeasures.com.*

Comment: One commenter recommended that CMS adopt a strong set of outcome, patient experience, and care transition measures for the next three-year payment determination periods. Many commenters suggested that CMS consider the following measure selection criteria for the HOP QDRP:

- Whether the measures are associated with better outcomes;
- The adoption of measures for one disease or condition at a time, thereby limiting the number of measures for a disease or condition;
- The collection of data via alternative mechanisms such as electronic health records (EHRs), registries, and claims;
- The operational burden on hospitals presented by data collection;
- Develop new measures with e-specifications;
- The harmonization of HOP QDRP measures with measures used by the Joint Commission, which are based on large patient volumes, evidence-based care, and patient outcomes;

- The harmonization of HOP QDRP measures with measures adopted for other quality reporting programs involving similar settings;
- The testing of measures in a variety of outpatient settings;
- The alignment of HOP QDRP measures with measures used by private payers; and
- The alignment of HOP QDRP measures with the national priority strategy as described in the NQF NPP project.

Response: We thank the commenters for the suggestions and for sharing their views regarding HOP QDRP measure selection. In section XVI.B.1. of this final rule with comment period, we have set out the criteria that we use to guide our decisions regarding what measures to add to the HOP QDRP measure set. As indicated in section XVI.B.1, we agree that quality measures should be associated with better outcomes for patients, that quality measures should be harmonized across care settings, and that measures selected for HOP QDRP should be aligned with national quality measurement and improvement priorities. We take these criteria into consideration when selecting measures for the HOP QDRP and we also consider the burden of data collection on hospitals relative to benefit that would result from public reporting and quality improvement.

Comment: Some commenters noted that none of the measures proposed through CY 2014 uses registry data and suggested that CMS explore outpatient registries as data sources for quality measure data. Commenters noted that data collection through registries is less burdensome as many hospitals are already reporting to registries. One commenter recommended that CMS use data submitted to established registries by hospitals. Commenters believed that registries impose and create readily-available reporting benchmarks which may be absent in EHRs. Commenters stated that if registries are used, clear criteria for participating registries must be defined and CMS should give adequate time for hospitals to prepare for registry participation. One commenter inquired whether CMS plans to propose that registries directly submit raw data to CMS with facility and patient identifiers.

Response: We thank the commenters for their support for registries as a vehicle for data collection. Although we agree that registries may have readily-available reporting benchmarks, we believe that EHR technology also has merits as an alternative data collection tool. Despite the fact that we did not propose any registry-based measures in the proposed rule, we remain interested in minimizing the burden associated with quality reporting and are continuing to explore registries as an alternative data collection vehicle for the future. If hospitals are participating in registries and submit the same data to those registries that they would otherwise have to submit for measures that are part of the HOP QDRP, we believe that the registry-based data would be an efficient alternative data source, and that this would prevent the hospital from having to report the same data twice. As the commenters stated, many hospitals are currently participating in a number of registries that collect data on quality measures on topics of interest to us. With respect to the comments on registry criteria and registry data submission, we thank the commenters for these suggestions and will consider them as we consider registry-based measures for the HOP QDRP. Should CMS propose to receive data from registries in the future, facility-level identifiers would be required for any hospital-level calculations that would be required by CMS, and patient-level identifiers may be required for any patient-level data required by CMS for validation purposes.

Comment: One commenter believed that using a registry as the sole source of data collection would place undue burden on hospitals. One commenter believed it is short-sighted to impose registry participation on hospitals when hospitals may soon be able to submit data using EHRs. One commenter suggested that registries that do not provide feedback to hospitals should be excluded from a qualified registry database should registries become an alternative data submission mechanism.

Response: We thank the commenters for sharing their views about registries and we will take them into consideration as we consider using registries in the collection and public reporting of HOP QDRP quality data.

Comment: Commenters commended CMS for encouraging the development and adoption of information technology standards across the health care industry that will support automated data collection and the reporting of clinical data from EHR systems. These commenters believed that such efforts will streamline hospital data submission procedures.

Response: We thank the commenters for their support of the adoption of information technology standards, such as EHRs, as a data collection vehicle. We envision that the EHRs will become an important data source as we develop electronic measures for the HOP QDRP. Initially, we expect that the finalized measure OP–18: Median Time from ED Arrival to ED Departure for Discharged ED Patients (discussed below) will be electronically specified by December 31, 2010.

Comment: Many commenters strongly supported CMS's proposal to adopt quality measures 3 years in advance to enable hospitals to better prepare for the impending reporting requirements, amid implementation of meaningful use objectives set forth in the HITECH EHR Incentive Program final rule and the transition into the ICD–10–CM/PCS code sets. Some commenters appreciated CMS's intention of providing greater predictability about the measures to be used in future years. Some commenters believed that proposing measures for more than one payment determination in a single rulemaking cycle provides more time for providers to study the measures and formulate comments while enabling CMS to more effectively develop comprehensive quality reporting programs.

Response: We thank the commenters for their support of our proposals. In proposing quality measures for three payment determinations, our goal is to assist hospitals in planning, meeting future reporting requirements, and implementing quality improvement efforts. The adoption of quality measures far in advance also enables CMS to create the infrastructure necessary to collect data on the measures.

Comment: Some commenters supported CMS's statement that the requirements for the future HOP QDRP payment determinations may change due to changing priorities and new legislative requirements. A few commenters suggested that instead of finalizing all the proposed measures for the next 3 years, CMS should ask for comments in the annual OPPS proposed rule for each year and only finalize measures pertaining to the year in which the measures are to be implemented. Some commenters requested that CMS provide an overall strategic perspective for the HOP QDRP 3-year expansion plan, the objectives set forth in the HITECH Act and the Affordable Care Act which promotes more integration of care across the health care delivery system. One commenter suggested setting a timeline in the three-year expansion plan for the NQF to review current HOP QDRP measures as rapidly as possible through its maintenance process, so that the HOP QDRP measures align with the NQF standards for endorsement and so

that their potential for quality improvement can be evaluated.

Response: We thank the commenters for supporting our acknowledgement that while we may finalize measures for multiple years, the measures are subject to change should we need to adapt in light of changing priorities and new legislation. Given the support we received on our proposal to propose new measures for three payment determinations, we will proceed in this direction for future measure proposal and finalization. With regard to our overall strategic perspective for the HOP QDRP 3 year expansion plan, we intend where feasible to propose to integrate into the HOP QDRP applicable meaningful use objectives set forth under the HITECH EHR Incentive Program as well as applicable quality priorities set forth in the Affordable Care Act.

While the NQF regularly reviews measures that it has endorsed as part of its regular 3-year measure reevaluation cycle (2-years for measures with time-limited endorsement), not all of the HOP QDRP measures are NQF endorsed.

Comment: Some commenters noted that under the HOP QDRP, hospitals must submit data on measures, whereas under the PQRI, individual eligible professionals or group practices submit the data. Commenters encouraged CMS to harmonize the two programs.

Response: We understand the commenters' desire for harmonization of our various quality reporting programs and we attempt to do so when feasible and practical. For example, we include the same AMI and Surgical Care measures in both the Hospital Inpatient Quality Reporting Program and the HOP QDRP. We note that the PQRI is a quality data reporting program for individual professional or group practices, while the HOP QDRP is a quality data reporting program that applies to hospital outpatient departments. A particular eligible professional or group practice generally provides a relatively specialized set of services with their patient population generally being much smaller than that enrolled in hospital outpatient departments. Given the different focus of these two programs, there are different considerations that are taken into account when establishing reporting requirements for each of these programs.

2. Retirement of HOP QDRP Quality Measures

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we finalized a process for immediate retirement of Hospital Inpatient Quality Reporting Program measures based on evidence that the continued use of the measure as specified raises patient safety concerns (74 FR 43864 through 43865). In circumstances such as those prompting immediate retirement of the AMI–6 measure from the Hospital Inpatient Quality Reporting Program in December 2008 (as discussed in the FY 2010 IPPS/RY LTCH PPS final rule (74 FR 43864 through 43865)), we do not believe that it would be appropriate to wait for the annual rulemaking cycle to retire a measure. We adopted this same immediate retirement policy for the HOP QDRP in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60635).

Specifically, we stated that if we receive evidence that continued collection of a measure that has been adopted for the HOP QDRP raises patient safety concerns, we would promptly retire the measure and notify hospitals and the public of the retirement of the measure and the reasons for its retirement through the usual means by which we communicate with hospitals, including but not limited to hospital e-mail blasts and the QualityNet Web site. We also stated that we would confirm the retirement of a measure retired in this manner in the next OPPS rulemaking cycle. However, for other circumstances in which we do not believe that continued use of a measure raises specific patient safety concerns, we stated that we intend to use the regular rulemaking process to retire a measure.

Comment: Several commenters encouraged CMS to establish consistent and transparent processes that address changes in evidence-based guidelines more quickly and to establish channels to exchange this type of information between CMS and measure developers. Commenters supported the measure retirement criteria and also encouraged CMS to retire measures under the following additional conditions:

- Another indicator exists that is better, or more accurately assesses good quality of care;
- A measure is no longer consistent with the standard of care or evidence-based guidelines; and
- When an outcome measure is available.

Response: We thank the commenters for their suggestions for measure retirement and will take them into consideration when evaluating whether to retire a measure in the HOP QDRP. At this time, we have not proposed to retire any measures from the HOP QDRP.

3. HOP QDRP Quality Measures for the CY 2012 Payment Determination

a. Retention of Existing HOP QDRP Measures for the CY 2012 Payment Determination

In the CY 2011 OPPS/ASC proposed rule (75 FR 46363), for the CY 2012 payment determination, we proposed to retain the existing 11 HOP QDRP measures. These measures continue to address areas of topical importance regarding the quality of care provided in HOPDs, and reflect consensus among affected parties. Seven of these 11 measures are chart-abstracted measures in two areas of importance that are also measured for the inpatient setting—AMI cardiac care and surgical care. The remaining four measures are claims-based measures that address imaging efficiency in HOPDs.

We invited public comment on our proposal to retain the existing 11 HOP QDRP measures for the CY 2012 payment determination.

Comment: Some commenters supported the retention of CY 2012 measures, specifically the prophylactic antibiotic measures.

Response: We thank the commenters for their support.

After consideration of the public comments we received, we have decided to adopt as final our proposal to retain the existing 11 HOP QDRP measures for the CY 2012 payment determination.

b. New Structural Measure for the CY 2012 Payment Determination

In the CY 2011 OPPS/ASC proposed rule (75 FR 46363), for the CY 2012 payment determination, we proposed to add one structural measure: "Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data" (NQF # 0489). Structural measures allow the assessment of the conduciveness of the provider environment to processes and technologies that enable delivery of high quality care. This particular structural measure assesses the extent to which a provider uses a certified/qualified EHR system that incorporates an electronic data interchange with one or more laboratories allowing for direct electronic transmission of laboratory data into the EHR as discrete searchable data elements. We believe that electronic transmission of laboratory data into EHRs would enable greater timeliness of results reporting, because the results of the reports would be transmitted to the HOPD as soon as the laboratory data are available which

allows for the merger with clinical information to provide laboratory value alerts and more timely clinical assessments. Electronic transmission of laboratory data can lead to cost efficiency, expedite the clinical decision process, reduce redundancy of laboratory orders, and reduce human errors.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this structural measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed in 2008 as part of an NQF project entitled "National Voluntary Consensus Standards for Health Information Technology: Structural Measures." Additionally, this measure was conditionally adopted by the HQA in 2010.

We proposed that this structural measure would be submitted by HOPDs beginning with January 1, 2011 discharges via a Web-based tool available on the QualityNet Web site that is currently employed for the collection of structural measures for the Hospital Inpatient Quality Reporting Program. For this structural measure, HOPDs would submit the number of encounters out of all encounters for which laboratory results were documented in the EHR. We invited comments on our proposal to add this new structural measure to the HOP QDRP measurement set and the submission process for the CY 2012 payment determination.

Comment: Some commenters appreciated that the proposed structural measure relates to an issue that is meaningful to consumers and purchasers, and believed that it is important for both public reporting and payment policy. One commenter noted that with timely receipt of results and a rapid diagnosis, patients can be treated while they are being seen and do not need to return or wait for a follow-up phone call. This fast turnaround time improves the quality of care and reduces medical costs. Furthermore, some commenters stated their belief that the addition of this measure to the HOP QDRP will raise hospital outpatient departments' electronic awareness, and motivate hospitals to adopt EHRs to improve care coordination, patient safety, and outcomes.

Response: We appreciate the commenters' support and encouragement and agree with commenters that this measure will improve the quality of care and promote the adoption of EHR technology.

Comment: One commenter stated that CMS will be better able to assess the EHR functionality of hospitals by adopting a similar measure for the HITECH EHR Incentive Program. One commenter was concerned about the duplication of this measure with the meaningful use objectives set forth in the HITECH EHR Incentive Program final rule. Many commenters did not support this measure and stated that the measure is not evidence-based and has not been field-tested. Some commenters did not support the measure because they believed the measure only assesses HIT functionality and does not assess the quality of care provided. Commenters recommended maintaining this measure solely as a meaningful use HIT functionality objective under the HITECH EHR Incentive Program.

Response: We strongly believe that the adoption of this measure in the two programs would have a complementary effect rather than a duplicative effect. Since hospital outpatient departments provide clinical laboratory testing services, we believe that this measure is appropriate for the HOP QDRP. The meaningful use objective set forth in the HITECH EHR Incentive Program requires the incorporation of clinical lab test results into EHR as structured data while the measure we are finalizing in this final rule with comment period assesses whether hospital outpatient departments are capable of receiving laboratory data directly into a qualified/certified EHR system as discrete searchable data.

Comment: Some commenters stated that this measure is too burdensome for providers, especially for providers with limited EHR capability or that are transitioning to EHR technology. The commenters stated that EHR vendors are still developing qualified/certified technology to accommodate this EHR capability. The commenters suggested that CMS delay the adoption of this measure until all hospitals have adopted qualified/certified EHRs. Commenters indicated this measure would be more appropriate for CY 2013 or CY 2014. Otherwise, it is counterproductive to penalize hospitals for lacking the type of EHR capability for which they have been given flexibility in adopting under the HITECH EHR Incentive Program.

A few commenters urged CMS not to impose this CY 2012 structural measure until providers have gained experience with Stage 1—Meaningful Use and demonstrated widespread participation in the Incentive Program. Commenters stated the proposed data submission date for this measure beginning with January 1, 2011 discharges may compromise a HOPD's flexibility derived from the HITECH EHR Incentive Program final rule (75 FR 44314), under which hospitals potentially have until CY 2014 to adopt qualified/certified EHRs for the purpose of participating in the incentive program to demonstrate meaningful use of EHR technology for any given payment year. Furthermore, for Stage 1 of meaningful use, the objective of "Incorporate clinical lab-test results into qualified/certified EHR technology" is a menu-set measure, and may be deferred. The commenters expected that many hospitals would choose to implement this measure early to avoid foregoing their full annual payment update. One commenter expressed concern that hospitals without qualified EHR systems that are capable of receiving lab data would be effectively precluded from receiving the full payment update for CY 2012.

Response: We understand the commenters' concerns. We note that many certified/qualified EHRs already have the capability to receive laboratory data directly into their systems as discrete searchable data. Since the hospital would satisfy the reporting requirement for the measure under the HOP QDRP by reporting "yes" or "no," we do not believe the adoption of this measure in the HOP QDRP will impede hospitals from receiving their full annual payment update in CY 2012 or beyond.

Comment: One commenter recommended that the measure focus only on the progress of implementing this EHR functionality by requiring hospitals to report quarterly updates on the progress of EHR technology adoption. Many commenters strongly recommended that CMS adopt a "yes/no" structural measure format as the measure indicator in order to minimize burden. Some commenters claimed that otherwise, it will be a huge burden to sort out the data. Specifically, these commenters requested clarifications on:

- The numerator and denominator definitions (for instance, what lab tests are to be included or excluded);
- The distinction between encounters where laboratory data are ordered as part of the encounter, and encounters where lab data are ordered as a standalone encounter;
- Issues for hospital-based clinics where patients choose to receive

laboratory services outside the hospital outpatient setting;

- The type of laboratories to which this measure applies, that is, if it is applicable to both external/reference lab interfaces and hospital internal facility laboratories;
- The definition of EHR versus qualified/certified EHR;
- The data collection frequency, for example, monthly, quarterly, or yearly; and,
- Whether the data collection includes all electronically submitted laboratory data from a physician's office or electronic submission of the number of tests out of all encounters including laboratory data not ordered in a physician's office.

Response: We thank the commenters for their input. To minimize the burden on hospitals in connection with this measure, we have adopted the commenters' suggestion and will only require hospital outpatient departments to disclose whether they have HIT with the capability to receive laboratory data electronically directly into a certified/qualified EHR as discrete searchable data. A "yes/no" format will be used for this structural measure.

After consideration of the public comments we received, we are finalizing this measure "Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data" for the CY 2012 annual payment update. Hospitals will be required to submit the information needed to calculate this measure via a Web-based collection tool beginning in July 2011 and HOPDs will report on the period from January 1, 2011 through June 30, 2011. The Web-based tool will be made available on the QualityNet Web site that we currently use to collect structural measures that we have adopted for the Hospital Inpatient Quality Reporting Program.

c. New Claims-Based Measures for the CY 2012 Payment Determination

In the CY 2011 OPPS/ASC proposed rule (75 FR 46364), for the CY 2012 payment determination, we proposed to add four new claims-based imaging efficiency measures to the HOP QDRP measurement set, all of which were listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641). Imaging efficiency is a new area of measurement that we first implemented in the HOP QDRP for the CY 2010 payment determination and subsequently retained for the CY 2011 payment determination. There are currently four claims-based imaging efficiency measures in the HOP QDRP measurement set (OP–8 through OP–11). The four new proposed imaging efficiency measures for the CY 2012 payment determination are: (1) Pre-Operative Evaluation for Low-Risk Non-Cardiac Surgery Risk Assessment, (2) Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI post CABG, (3) Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT), and (4) Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache.

The first new proposed imaging efficiency measure for the CY 2012 payment determination seeks to calculate relative use of stress echocardiography, stress MRI, and SPECT MPI prior to low-risk non-cardiac surgical procedures in the 30 days preceding the surgery. The second new proposed claim-based imaging efficiency measure for the CY 2012 payment determination seeks to estimate relative use of stress echocardiography and SPECT MPI in asymptomatic patients less than five years after a coronary artery bypass graft (CABG) procedure.

Cardiac imaging is an area that was not addressed in CMS' first set of outpatient Imaging Efficiency measures. It is among the most common imaging services in the Medicare population. In the hospital outpatient setting, 762,419 SPECT MPI, Stress MRI and Stress Echocardiography procedures were performed in 2008 alone.[2] Further, between 1998 and 2006, the rate of myocardial perfusion imaging (MPI) use in Medicare beneficiaries increased 51 percent among cardiologists in the hospital setting, and by 215 percent in private offices. During the same time period, total Medicare Part B payments for MPI across all settings of care increased by 227 percent.[3]

SPECT MPI, Stress MRI, and Stress Echocardiography are specific procedures that must be ordered by a physician to be performed. Therefore, there is a distinct opportunity for the physician to order this procedure prudently based on best practices. While SPECT MPI, Stress MRI, and Stress Echocardiography enhance the quality of care when used appropriately, inappropriate usage of imaging would cause unnecessary waste of services, contribute no benefit to the quality of care, and could increase the patient's risk of cancer. An analysis by Gibbons *et al.*[4] found that, of all SPECT MPI procedures performed at the Mayo Clinic Rochester in May 2005, 14 percent were considered inappropriate using criteria published by the American College of Cardiology Foundation and the American Society of Nuclear Cardiology, and an additional 11 percent were of indeterminate appropriateness.[5] This study also found that during the same time period, 18 percent of all stress echocardiograms performed were inappropriate, and an additional 9 percent were indeterminate.

The third and fourth new proposed imaging efficiency measures for the CY 2012 payment determination pertain to appropriate use of Brain CT imaging in HOPDs. These are "Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)," and "Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache."

A report in the New England Journal of Medicine [5] raised serious concerns about the use and overuse of CT scanning, stating that for an estimated 62 million CT scans being performed per year, a third are unnecessary, resulting in patient safety issues including unnecessary radiation and contrast material exposure, and the danger associated with "false positive" findings. A CT scan exposes the patient to higher doses of radiation than a conventional x-ray and increases the patient's risk of cancer.

Brain CTs are often ordered in addition to a sinus CT for patients with sinusitis because headache is a common symptom related to sinusitis. However, simultaneous CT sinus and brain imaging for headache without suspected complications is generally considered inappropriate, as the standard anatomic coverage of a CT of the head includes large portions of the paranasal sinuses; thus, ordering both procedures is duplicative and inefficient.[5] [6] The third

[2] The Lewin Group analysis of Medicare Calendar Year 2007 claims data prepared for the Centers for Medicare & Medicaid Services, HHS Contract No: HHSM–500–2005–0024I, Order No. 0002.

[3] Levin DC, Rao VM, Parker L, *et al.* Recent payment and utilization trends in radionuclide myocardial perfusion imaging: Comparison between self-referral and referral to radiologists. J Am Coll Radiol 2009;6:437–441.

[4] Gibbons RJ, Miller TD, Hodge D, *et al.* Application of appropriateness criteria to stress single-photon emission computed tomography sestamibi studies and stress echocardiograms in an academic medical center. J Am Coll Cardiology 2008;51:1283–9.

[5] Brenner DJ, Hall EJ. November 29, 2007. Computer Tomography—An Increasing Source of Radiation Exposure. New England J of Medicine 2007:357(22): 2277–84.

[6] Appropriateness Criteria—Headache. Reston, VA: American College of Radiology, 2009. Accessed November 25, 2009 at *http://www.acr.org/*

new proposed imaging efficiency measure for the CY 2012 payment determination "Simultaneous Use of Brain CT and Sinus CT" assesses the extent to which patients with a headache who have a brain CT also have a sinus CT performed on the same date at the same facility. The measure excludes patients with trauma diagnoses, tumors or orbital cellulitis.

The fourth new proposed imaging efficiency measure for the CY 2012 payment determination, "Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache," assesses the extent to which patients presenting with a headache receive brain CT studies. The measure excludes patients admitted or transferred to an acute care hospital, patients with lumbar punctures, dizziness, paresthesia, lack of coordination, subarachnoid hemorrhage or thunderclap headaches. The lifetime prevalence of headache is over 90 percent for men and women and according to some studies, headache accounts for 16 million physician visits annually in the U.S.[7] According to Goldstein et al. (2006) for U.S. emergency departments (EDs) from 1992 to 2001, headaches represented approximately 2 percent of U.S. ED visits.[8] An analysis of 2007 Medicare claims data found that approximately 200,000 Medicare beneficiaries had a visit to an ED with a primary diagnosis of headache with about half of these patients (not taking into account the previously mentioned exclusion of lumbar punctures, dizziness, paresthesia, lack of coordination, subarachnoid hemorrhage or thunderclap headaches) receiving a Brain CT coincident with the ED visit.[9] Unnecessary or duplicative studies are inefficient and detrimental to the patient because CT exposes the patient to higher doses of radiation than conventional x-ray and increases the patient's risk for cancer.[10]

Concern over the inappropriate use of CT Imaging in the ED setting has been driven by three major factors: False positive interpretations, radiation exposure, and cost. There is generally a lower threshold for ordering neuro-imaging for headache in the ED because of physician time constraints and lack of ED physician familiarity with headache presentation.[11] Because of this lower threshold, the measurement of the use of CT Brain in the ED for patients with a diagnosis of a traumatic headache can raise awareness of the need for appropriate use of CT brain imaging in the ED and, as a result improve patient safety through reduction in unnecessary radiation exposure.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, these measures are appropriate for measuring quality of care in the hospital outpatient department setting. These measures also meet the consensus requirement because these measures were developed through a consensus-based process involving stakeholder input. For the CY 2012 payment determination, we proposed to calculate these four measures using Medicare claims from CY 2010. We invited comments on our proposal to add these four new imaging efficiency measures to the HOP QDRP measurement set based on Medicare claims from CY 2010 for the CY 2012 payment determination.

Like the current imaging efficiency measures in the HOP QDRP measurement set, these four measures are based on Medicare claims and will not require additional data submission on the part of hospitals. All four of these proposed measures are currently undergoing NQF review, and specifications for these measures are available at *http://www.imagingmeasures.com*.

- Imaging Efficiency Measures

We received several general comments on the proposed new imaging efficiency measures.

Comment: Some commenters agreed that the 4 proposed new claim-based imaging efficiency measures will enhance patient safety in the hospital outpatient setting, based on the evidence of the potential harmful effects of excessive radiation exposure associated with the use of imaging services. One commenter encouraged CMS to publish analysis findings, and seek public comments before making policy decisions to adopt these four measures. This commenter believed that the analysis of utilization of the four proposed imaging procedures should be performed separately.

Response: We thank the commenters for the support and suggestions. We developed the proposed Imaging Efficiency measures by means of a rigorous process that included reviewing current literature and clinical guidelines, and seeking the recommendations of a technical expert panel. Also, prior to proposing to adopt these measures for the HOP QDRP, we asked for public comment on them and considered the comments as we refined the measure specifications. The rulemaking process provided another opportunity for the public to provide input and voice support and concerns regarding the proposed measures. We will work on publishing findings for the imaging efficiency measures.

Comment: One commenter noted that the American College of Cardiology (ACC) and the American Society of Nuclear Cardiology (ASNC) guidelines for imaging are conservative and that their guidelines tend to be based on expert opinion rather than on evidence data. The commenter stated that when the clinical conditions for some patients do not fall within the scope of these guidelines, providers are compelled to perform the imaging study. According to the commenter, imaging studies performed under such circumstances should not be automatically considered inappropriate or medically unnecessary. Another commenter requested that before CMS adopts the proposed imaging measures, it should conduct a comprehensive assessment of the impact of the existing imaging measures and the appropriateness of preoperative use of cardiovascular imaging using the ACC and the American College of Radiology (ACR) Appropriateness Criteria as references. One commenter suggested that CMS adopt the quality data measures used by the the ACC registry for purposes of consistency with the cardiovascular community's appropriateness criteria and in order to reduce burden.

Response: Our measure development process includes an extensive review of available imaging guidelines, including the ACC and the ACR Appropriateness Criteria and peer-reviewed literature, as well as collaboration with a technical expert panel. Additionally, in instances

SecondaryMainMenuCategories/quality_safety/app_criteria.aspx

[7] Mellion ML, Jayaraman MV. August 2007. Use of neuroimaging in the workup of headache. Med Health RI.; 90(8):249–50.

[8] Goldstein JN, CA Camargo, AJ Pelletier, JA Edlow. 2006. Headache in the United States Emergency Departments: demographics, work-up and frequency of pathological diagnoses. Cephalalgia; 26(6) 684.

[9] The Lewin Group analysis of Medicare Calendar Year 2007 claims data prepared for the Centers for Medicare & Medicaid Services, HHS Contract No: HHSM–500–2005–00241, Order No. 0002.

[10] Brenner DJ and Hall EJ. November 29, 2007. Computed Tomography—An Increasing Source of Radiation Exposure. N Engl J Med; 357(22):2277–84.

[11] Ward TN, Leven M, Phillips JM. Evaluation and management of headache in the emergency department. Med Clin N Am 2001;85(4) 971–85.

when there is uncertainty about the appropriateness of an imaging study, they are treated as "exclusions" in the measurement (that is, they are not included in the measurement calculation). Regarding the ACC registry measures; we will consider this suggestion and will evaluate the feasibility of including these measures in the HOP QDRP program.

Comment: One commenter strongly believed that the proposed imaging efficiency measures are in fact "gross unadjusted utilization rates" measures and stated that they should be named as such to avoid confusion to the public and the payers.

Response: We do not believe that the proposed imaging efficiency measures should be named differently. We have undertaken work on imaging efficiency as an educational effort, aimed at educating the public about the appropriate use of and risks associated with imaging services and respective optimal imaging treatment guidelines. We recognize that imaging services may be essential in the diagnosis and treatment of certain conditions; however, we also recognize that both the over- and underutilization of these services may affect both the safety and quality of care an individual receives. The proposed outpatient imaging efficiency measures address important patient safety concerns related to exposure to unnecessary radiation and/or contrast materials, and promote the efficient use of imaging procedures. For this reason, we do not believe that they are simply "gross unadjusted utilization rates" as the commenter suggests.

Comment: Some commenters did not support the measures for the following reasons: (1) The absence of NQF-endorsement; (2) the lack of evidence-based correlation between the number of imaging studies performed and the quality of care provided; (3) absence of field-testing; and (4) absence of benchmarks.

Response: The area of imaging efficiency quality measures is relatively new and challenging. In conjunction with our rigorous consensus-based measure development process, we also reviewed Medicare data which indicates that there are HOPDs that have imaging practice patterns that are very different than the majority of hospitals. We anticipate that the public reporting process will heighten provider awareness of patient safety and encourage hospitals to proactively improve their quality of care.

By way of illustration, our analysis of 2008 Medicare claims data found that for OP–10 Abdomen CT Use of Contrast Material, the national average ratio was 0.191, with half of the hospitals at or below 0.107. However, 5 percent of the hospitals had measure ratios at or above 0.685, and 1 percent of the hospitals had ratios at or above 0.811. Radiation exposure from a single CT scan of the abdomen is about 11 times higher than it is for an ordinary x-ray of the abdomen. For a combination CT scan, radiation exposure is 22 times higher than it is for an x-ray of the abdomen because the patient is given two scans. We continue to believe that the act of quality measure reporting and its impact can be powerful catalysts for improvement.

As we stated in a response to a previous comment, we have undertaken the work on imaging measures as an educational effort, aimed at educating the public about the appropriate use of and risks associated with imaging services and the best practices for utilizing them. We believe that identifying imaging practice patterns is consistent with educational and quality improvement efforts for hospitals, and public reporting related to these practice patterns can play an important role in the quality improvement process.

Additionally, the collection of data on the proposed imaging efficiency measures is a foundation building exercise that will help us determine the distribution of provider experiences and results across a national data set. With regard to the commenters' concern that there has been no field-testing of these measures, we do not believe that field-testing is necessary for these claims-based measures because we can calculate them for all OPPS hospitals based on claims. Outpatient imaging is a common and frequently performed diagnostic and therapeutic procedure. With respect to commenters' concern about the lack of benchmarks, we recognize that while the quality and safety of outpatient imaging services are critically important, few national standards exist to address the variations in the delivery of outpatient imaging services. However, analysis of Medicare outpatient hospital claims data indicates that some hospital outpatient departments have patterns of care in their use of imaging services that are significantly different than the patterns of care seen in most other hospital outpatient departments. We believe that identifying these practice patterns is consistent with educational and quality improvement efforts for these providers, and that public reporting related to these patterns can play an important role in the quality improvement process.

We intend to publicly report average rates and ratios of imaging study utilization, so that a hospital may compare its values with national and State values. We note that there are currently no benchmarks or CMS definitions of appropriate usage rates associated with these measures. However, as HOPDs become more familiar with these measures, we are hopeful that such benchmarks can be developed.

Comment: A commenter believed that the inclusion of risk-adjustment and a "within range" in imaging measures are crucial for a fair and unbiased comparison of different facility use rates.

Response: As stated above, the outpatient imaging efficiency measures were developed after an extensive review of literature and medical society guidelines, such as those published by the ACR, the ACC Foundation and the American College of Physicians, and after consultation with a technical expert panel. As a result of this process, we were able to identify medical conditions for which imaging services are considered appropriate, and these conditions will be treated as "exclusions" and will not be included in the measure calculations. We were also able to conclude, based on this process, that we do not need to risk adjust the measures once the exclusion criteria have been applied. Accordingly, the outpatient imaging efficiency measures will not be risk adjusted but instead will be calculated as raw/observed rates after the exclusion and inclusion criteria are applied.

Comment: Some commenters stated that patient variables coupled with a lack of clinical information in the chart make it difficult for a physician to gauge if an imaging test is appropriate for a patient. Some commenters were concerned that the proposed claims-based imaging efficiency measures do not capture all of the medical reasons why a physician would order a particular imaging study. Several commenters were concerned that they may not have the opportunity to review the claims data and to provide CMS with additional clinical information for appropriate exclusions to be made.

Response: During the development of the proposed outpatient imaging efficiency measures, we completed extensive literature reviews and analyzed appropriate medical guidelines to determine the appropriateness of imaging studies for various medical conditions, such as cancer and trauma. In addition, we looked to see whether patient variables, such as age, needed to be taken into account based on the medical guidelines. As a result of this research, certain diagnoses will be excluded from

the measure calculations for each of the proposed imaging measures because we have concluded that an imaging study would be appropriate for those diagnoses.

We have developed the specifications for the proposed imaging efficiency measures by looking at Medicare claims data, which we will also use to calculate the measures. We believe that the use of claims data is a non-burdensome data collection approach for hospitals. During the measure development process, we have determined that additional clinical information beyond what is present on claims is not necessary in order to identify exclusions. However, we regularly review whether additional codes should be added in order to determine exclusions.

Additionally, as we do for all HOP QDRP measures, we will make various resources available to hospitals, including measure specifications and literature, and will send a hospital specific report to each hospital prior to the time we publicly report the measures. The hospital specific reports will contain average State and National measure calculations, as well as measure specific data for the hospital, so that the hospital may review the measure calculations. This allows hospitals to review the ordering behavior of physicians. The intent of the proposed imaging efficiency measures is to encourage hospital outpatient departments to improve their quality of care and to equip consumers with quality of care information to help them make more informed decisions about their health care.

Comment: A few commenters were concerned about the potential perception that lower imaging usage rate is better or that certain uses of imaging technologies results in inferior care being provided to patients.

Response: The goal of the imaging efficiency measures is not to suggest that lower rates of imaging services are necessarily better or that certain types of imaging studies are better than the others, but to promote the efficient use of imaging procedures in hospital outpatient departments. Our analysis of Medicare claims data indicates that there are hospital outpatient departments that use imaging services significantly more or less than most other hospital outpatient departments. The proposed imaging measures are intended to identify outlier practice patterns, which we believe is consistent with our educational and quality improvement efforts, and for which public reporting can play an important role in the quality improvement process.

Comment: One commenter noted that different hospitals have different preoperative checklists for surgery and that the documentation of imaging studies will differ accordingly.

Response: The proposed imaging efficiency measures are claims-based measures, which means that hospitals do not need to submit any additional data in order for us to calculate them under the HOP QDRP.

We also received comments on individual imaging measures.

• Cardiac Imaging Preoperative Risk Assessment for Non-Cardiac Low-risk Surgery

(This measure was labeled Pre-operative Evaluation for Low-Risk Non-Cardiac Surgery Risk Assessment in the proposed rule (75 FR 46364). However, we are changing the title in order to make explicit reference to the type of preoperative evaluation for risk assessment and the type of imaging that was performed.)

Comment: A few commenters supported the proposed measure and noted that the metric is reasonable to monitor unnecessary imaging testing and expenses.

Response: We thank the commenters for their support and their recognition of the importance of this proposed measure.

Comment: Two commenters believe that because the imaging study must be ordered by a physician, the proposed measure is focused on a physician service, rather than on the quality of care performed by a hospital outpatient department. Commenters requested clarification on the accountability for the imaging procedure when it is ordered by a physician outside the hospital in which the study is performed. One commenter recommended that the proposed measure be included in the PQRI so that physicians who order the study will also be held accountable.

Response: We thank the commenters for the suggestions. The intent of the Cardiac Imaging Preoperative Risk Assessment for Non-Cardiac Low-risk Surgery measure is to encourage both hospitals and clinicians to improve their quality of care and to equip consumers with quality of care information to help them make more informed decisions about their health care. We strongly believe that this measure will provide hospitals with an opportunity to look for areas of improvement. Because hospitals submit claims to Medicare for the services they furnish both to inpatients and outpatients, they have a responsibility to ensure that the services they furnish and that are paid by Medicare are appropriate and necessary.

Comment: Some commenters cited the Appropriateness Criteria, established by the ACC and endorsed by the American Society of Echocardiography (ASE), which state that a stress echocardiogram may be appropriate for low-risk non-cardiac surgery patients if they experienced cardiac symptoms within 30 days prior to surgery. Commenters also stated that, in other instances, the imaging study may be ordered 30 days prior to the surgery for reasons not tied to pre-operative evaluation. Therefore, the commenters believed that the measure numerator should exclude patients who underwent stress imaging within 30 days of low-risk surgery for unrelated, acceptable indications.

Response: Clinical guidelines, including those published by or in collaboration with the ACC, ASE, ASNC, AHA, ACP, ACEP, SCAI, and SCMR, generally indicate that cardiac imaging is not needed prior to low-risk surgery in low-risk patients; however, it is not possible to determine high-risk patients from claims data. For this reason, we do not expect the measure ratio to be zero.

Comment: Some commenters remarked that given the infrequent occurrence of low risk non-cardiac surgeries, this measure may not actually assess whether there are significant differences in the provision of the imaging tests and their impact on the quality of care provided.

Response: We understand the commenters' point of view. The number of imaging studies that the measure assesses may not be large, however for the reasons we discussed above, we believe this measure can satisfy our goal to identify outlier practice patterns and encourage HOPDs to improve their quality of care.

Comment: Two commenters asked for clarifications on data collection, the potential need for separate codes, and the criteria for determining overuse of echocardiography for the proposed "Pre Operative Evaluation for Low-Risk Non-Cardiac Surgery Risk Assessment" measure.

Response: The specifications for this measure are available online through QualityNet for HOP QDRP-adopted measures and through *http://www.imagingmeasures.com.* These specifications include the diagnostic and procedural codes included in the measure, as well as any exclusion criteria that will be applied.

Comment: A commenter inquired if a stress test can be ordered for a patient having low risk surgery if chest pain or

dyspnea on exertion (DOE) are documented in the history and physical, provided the surgery diagnosis is listed on the order form or the care plan as well.

Response: The goal of the measure is not to dictate how to practice medicine or under what circumstances imaging studies should be ordered. We refer the commenter to the measure specifications on Preoperative Risk Assessment at *http://www.imagingmeasures.com* for detailed information about the measure. We also refer readers to our previous discussion about exclusion criteria for the quality measures.

Comment: A commenter was concerned about the potential absence of documentation by a referring physician regarding which low-risk surgery would be performed.

Response: The specifications for the measure include a list of the applicable low-risk surgeries. We expect that the referring physician would document which low-risk surgery was going to be performed.

Comment: Some commenters suggested that CMS delay adopting this measure until meaningful differentiation of quality is provided by the imaging efficiency measure.

Response: This measure shows substantial variation among hospitals, and thus presents an opportunity for hospitals to engage in quality improvement efforts. We believe that preoperative risk assessment for low-risk surgeries is an important clinical topic for quality improvement.

Comment: Commenters requested that CMS define the term "low-risk" and provide the sources used to make the determination and identify what is the appropriate usage rate.

Response: For the Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery measure, low-risk surgery is defined in the measure specifications as "cardiac death or myocardial infarction" in less than 1 percent of performed procedures. This definition was chosen after a literature review including Auerbach A., Goldman L., Assessing and reducing the cardiac risk of noncardiac surgery. Circulation. 2006 Mar 14;113(10):1361–76; Schouten O., Bax J., Poldermans D., Assessment of cardiac risk before non-cardiac general surgery. Heart. 2006 Dec 92 (12): 1866–1872. Doi: 10.1136/hrt.2005.073627; Gregoratos G., Current guideline-based preoperative evaluation provides the best management of patients undergoing noncardiac surgery. Circulation. 2008 Jun 17;117(24):3145–51; discussion 3151; Wijeysundera DN, Austin PC, Beattie WS, Hux JE, Laupacis A., A population-based study of anesthesia consultation before major noncardiac surgery. Arch Intern Med. 2009 Mar 23;169(6):595–602. PMID: 19307523; and Fleisher LA, et al, ACC/AHA 2006 Guidelines update on perioperative cardiovascular evaluation for noncardiac surgery: focused update on perioperative beta-blocker therapy: a report of the ACC/AHA Task Force on Practice Guidelines. Circulation. 2006 Jun 6;113(22):2662–74. The categories for low-risk surgery are also identified in the measure specifications, and CMS consulted with the ACC to harmonize the list of low-risk surgeries that are included in the measure. ACC Appropriateness Criteria for SPECT MPI, include low-risk categories such as endoscopic procedures, superficial procedure, cataract surgery, and breast biopsy. Using these categories, we identified what CPT procedure codes would apply for purposes of the measure. With regard to the comment about usage rate, medical specialty society guidelines generally indicate that cardiac imaging is not needed prior to low-risk surgery in regular- and low-risk patients. As noted above, we do not expect the measure ratio to be zero. The purpose of the measure is to identify HOPD practice patterns and to alert HOPDs if their imaging patterns appear to be significantly different than the imaging patterns of the majority of HOPDs.

After consideration of the public comments we received, we are finalizing the Cardiac Imaging Preoperative Risk Assessment for Non-Cardiac Low-risk Surgery measure for the CY 2012 payment determination.

- Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI Post-CABG

Comment: A few commenters stated that the measure is consistent with currently published guidelines. Furthermore, commenters believed the measure has a reasonable metric to monitor unnecessary testing and expenses, and addresses the appropriate use of SPECT to detect graft occlusions and progressive disease in native arteries, especially if the denominator population is asymptomatic patients who are free of both signs and symptoms.

Response: We appreciate the commenters' recognition of the benefits of this measure. However, as we describe more fully below, we are opting to not finalize it at this time.

Comment: A commenter stated that there is no clinical consensus on the appropriateness of the performance of stress imaging within 5 years of CABG. The commenter was unclear about the purpose of tracking utilization of stress imaging post-CABG.

Response: This measure was developed through a consensus-based process that included consultation with a technical expert panel, an analysis of available and appropriate medical guidelines, and a review of peer-reviewed literature. Guidelines consulted in the development of this measure were issued by numerous medical societies, including the ACC Foundation, American Heart Association, American Society of Echocardiography, American College of Emergency Physicians, American College of Radiology, Society of Cardiovascular Computed Tomography, and American Society of Nuclear Cardiology.

Cardiac imaging is among the most common imaging services in the Medicare population, and has experienced significant growth in the past decade. Nuclear imaging has been one of the major contributors to the growth in radiation exposure in the Medicare population. SPECT MPI, Stress MRI, and Stress Echocardiography are specific procedures that must be ordered by a physician to be performed. We believe that the adoption of this measure would provide an opportunity for HOPDs to evaluate their practice patterns and reduce the incidence of unnecessary imaging studies without compromising the quality of care that they provide to their patients. However, for reasons discussed below, we are not finalizing this proposed measure at this time.

Comment: Some commenters noted that the proposed measure, with the exclusions as written, may result in insufficient denominators and numerators, and this could lead to statistically invalid comparisons of hospital care. Commenters were concerned that the exclusions may not include asymptomatic patients (such as in some diabetic patients or women), or all of the postoperative issues that could appropriately trigger the use of stress perfusion testing, for example, new onset or other indications of heart failure, new left ventricular enlargement and ventricular arrhythmias, chest pain, and dyspnea on exertion. Additionally, commenters noted that providers may not have access to all of the clinical information required to consider and fully evaluate such issues. One commenter was concerned that the measure may not correctly identify the symptomatic status of the patients based on the ICD–9 codes obtained from claims data. Commenters suggested that CMS not adopt the measure until it has

been endorsed by the NQF, has undergone more refinement to allow for differentiation of quality and been appropriately structured to avoid unintended consequences.

Response: The NQF Steering Committee has suggested a number of changes to this measure, including expanding it to include Percutaneous Coronary Intervention (PCI). The Steering Committee encouraged us to consider the recommended changes and to submit a revised measure to NQF at a later date. While we are not required to adopt only NQF-endorsed measures, we want to take the opportunity to consider the suggestions made by the Steering Committee for potential improvements to the measure and further examine some of the technical issues raised during the Committee's discussion. Therefore, we are not finalizing this measure for the CY 2012 payment determination.

Comment: One commenter asked for clarification on data validation for this measure. The commenter was concerned by the fact that physicians do not routinely indicate a diagnosis of "Post-CABG" on orders for the diagnostic services and this may hamper CMS's efforts to identify these cases through claim submission.

Response: As noted above, we have opted to not finalize this measure at this time. However, should we decide to finalize it in the future, we would calculate it using Medicare FFS claims data.

Comment: Some commenters believe that the measure is inconsistent with the ACC Appropriate Use Criteria, which state that the determination of SPECT imaging appropriateness for patients who are less than 5 years post-CABG includes consideration of physician judgment and patient condition. Two commenters were concerned that the adoption of this measure will suggest to the public that there is consensus that post-CABG use of the imaging studies is inefficient and is not high quality care.

Response: We do not agree that the measure is inconsistent with the ACC Appropriate Use Criteria, or that its adoption into the HOP QDRP will suggest to the public that post-CABG use of imaging studies is always inefficient. However, as explained above, in light of the NQF Steering Committee's recent recommendations to expand the measure to include PCI, we have decided to not finalize the measure at this time.

After considering the public comments we received, we are not finalizing the Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI post-CABG measure for the CY 2012 payment determination. We will, however, consider proposing this measure for the HOP QDRP in the future.

- Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)

Comment: Some commenters believed that the percentage of patients who receive both a brain CT and a sinus CT on the same day is so small (only 5 percent) that it would be hard to pinpoint how many of the scans would be considered inappropriate or over-utilized. Alternatively, commenters recommended that CMS adopt the "CT dose reduction" measure developed by the AMA Consortium and the ACR. Commenters believed that this measure would apply to a larger number of patients and that it could be used to track larger critical organ doses.

Response: The intent of the Simultaneous Use of Brain CT and Sinus CT measure is to assess whether potentially unnecessary sinus CTs are being performed on patients who have already undergone brain CTs. We do not intend for the rate to be reduced to zero. Despite the fact that a small proportion of claims indicate same day combined studies, we have substantial concerns regarding radiation exposure from the simultaneous use of these two imaging modalities. Our analysis of Medicare data for 2008 found that over 68,000 Medicare patients received this dual radiation exposure. Although we agree that the relative incidence of dual imaging would be low, we believe that the measure establishes a clear opportunity for improvement by heightening providers' awareness of patient safety in imaging studies.

Comment: One commenter felt that there was an accountability issue because a physician orders the study and the hospital outpatient department follows the order and provides the imaging service.

Response: The intent of this imaging efficiency measure is to encourage hospitals to improve their quality of care. Although we recognize that these studies are ordered by physicians, we believe that hospitals have a responsibility to ensure that the services they furnish and for which they are paid by Medicare are appropriate and necessary. This measure will provide hospitals with an opportunity to look for areas of improvement and, we hope, reduce the incidence of unnecessary radiation exposure.

Comment: One commenter supported the measure's focus on patient safety and unnecessary radiation exposure.

Response: We thank the commenter for the support.

After considering the public comments we received, we are finalizing the Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT) measure for the CY 2012 payment determination.

- Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache

Comment: Some commenters supported the measure because (1) It targets an area of known overuse, (2) it is consistent with ACR Appropriateness Criteria which indicates that CT of the head is usually appropriate in a wide range of clinical circumstances (for example, sudden onset of severe headache, sudden onset of unilateral headache, suspected carotid or vertebral dissection, ipsilateral Horner's syndrome, new headache in a patient older than 60 with a sedimentation rate high than 55, etc.), but is not appropriate for patients who present with a headache but do not have other neurological symptoms, and (3) it serves a public health need. Commenters noted that headache imaging performed in the ED on patients with non-focal neurologic exams yields a low percentage of positive studies, and they believed that cumulative population radiation dose is a valid concern. Commenters believed the measure's exclusion criteria are well thought out.

Response: We appreciate the commenters' recognition of our efforts and thank them for the support.

Comment: Some commenters opposed this measure because they believed the measure is a flawed utilization measure rather than a true efficiency measure. Commenters stated that the measure does not follow published guidelines for care and will not produce reliable and valid results about the quality of care. A commenter was concerned that ED physicians may face a liability issue if they do not order a CT in these circumstances.

Response: We disagree with the commenters. As we explained earlier, our consensus-based measure development process for this imaging measure was rigorous and included an extensive review of available imaging guidelines and peer-reviewed literature, as well as collaboration with a technical expert panel. The guidelines used in the development of this measure included those from the U.S. Headache Consortium in collaboration with the American Academy of Neurology, the Singapore Ministry of Health, the American College of Emergency Physicians, and the American College of

Radiology. We note that the imaging efficiency measures are designed to look at practice patterns in the aggregate instead of individual case decisions. We believe that patient safety concerns should play a role in medical decision making in addition to other concerns (such as malpractice liability).

After considering the public comments we received, we are finalizing the Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache measure for the CY 2012 payment determination.

In summary, after consideration of the public comments we received, we are finalizing three imaging efficiency measures: "Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery"; "Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)"; and "Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache" for the CY 2012 payment determination and subsequent payment determinations.

d. New Chart-Abstracted Measures for the CY 2012 Payment Determination

In the CY 2011 OPPS/ASC proposed rule (75 FR 46365), we proposed to add one new chart-abstracted measure to the HOP QDRP measurement set for the CY 2012 payment determination: "Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (*with Probable Cardiac Chest Pain*) Received within 60 minutes of arrival." Troponin is used to help diagnose a heart attack, to detect and evaluate mild to severe heart injury, and to distinguish chest pain that may be due to other causes.

This measure is based upon the existing ED–AMI/Chest Pain populations for which we have adopted five measures in the current HOP QDRP measurement set. In the proposed rule, we noted that this measure was undergoing NQF review.

Both patients and clinicians are affected by the timeliness of laboratory reporting.[12] Decreasing laboratory turnaround times increases ED efficiency, specifically by decreasing diversion time from treatment of patients and decreasing length of stay.[13] Decreasing the number of hours a day on diversion as well as decreasing patients' lengths of stay in EDs allows for the treatment of a greater number of patients. In addition, the length of hospital stays and mean turnaround times have been found to be correlated.[14] Efficiencies in throughput with tasks can lead to less diversion, less overcrowding, fewer elopements and less financial loss.[15]

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because this measure underwent development through a consensus-based measure development process involving stakeholder input. We noted in the proposed rule that we anticipated that this measure would be endorsed by the NQF.

In the proposed rule we stated that if adopted, data collection for this measure would begin with January 1, 2011 discharges, and data would be submitted quarterly.

We invited public comment on our proposal to add this new chart-abstracted measure to the HOP QDRP measure set and the submission process for the CY 2012 payment determination.

Comment: Many commenters supported this measure because it supplements the existing measures on the topic of heart attack/chest pain care for ED patients who are transferred to other hospitals for advanced cardiac care. Commenters noted that the proposed time frame is reasonable and the measure is a useful quality metric. Commenters commended CMS for proposing to adopt the measure because it relates to an issue that is meaningful to the public, and they recognized that the measure is important for both public reporting and payment policy. One commenter appreciated that only one chart-abstracted measure was proposed for the CY 2012 payment determination as this would lessen the burden on hospital outpatient departments.

Response: We thank the commenters for their support and appreciation of our efforts to limit the reporting burden for hospitals.

Comment: A few commenters were very concerned about the burden generated from chart-abstraction for this measure and recommended that CMS first assess whether HOPDs have the ability to collect and report additional chart-abstracted measures before proceeding to adopt this measure. Commenters suggested a "yes/no" measure format to minimize the reporting burden. One commenter requested delaying the implementation of this measure until there is NQF-endorsement.

Response: We thank the commenters for their suggestions. We recognize the additional burden of collection of data via chart abstraction. However, we anticipate that the additional data that hospitals will need to submit for this measure will be minimal because there are only two chart abstracted data elements required, and the measure applies to a patient population for which charts are already being abstracted for other measures (ED–AMI). This measure is currently under NQF review and is expected to be endorsed in the fall of 2010. However, as we have previously stated, NQF endorsement is not a requirement for adopting measures for the HOP QDRP.

Comment: Many commenters were concerned that the measure may have an unintended consequence of inadvertently encouraging hospitals to hold patients in the EDs longer than necessary in order to run the Troponin test and comply with the measure requirement. A commenter was concerned that the Troponin test may hold up lab slots and prolong the lab waiting time for other patients. Other commenters were concerned about the applicability of the measure to smaller hospitals which have less resources and less technology and, thus, may not be able to meet the requirement in a timely manner. One commenter recommended field testing the measure at small hospitals to determine its feasibility in those facilities.

Response: The measure does not require HOPDs to run a Troponin test on patients for management of acute myocardial infarction in the ED. However, we believe that use of the test facilitates decision making in the treatment of time sensitive conditions such as AMI and, for that reason, believe that results of the test should be

[12] Howanitz JH, and Howanitz PJ. Laboratory results: Timeliness as a quality attribute and strategy. Am J Clin Pathol. 2002 Sep;116(3):311–5.

[13] Storrow AB, Zhou C, Gaddis G, Han JH, Miller K, Klubert D, Laidig A, and Aronsky D. Decreasing lab turnaround time improves emergency department throughput and decreases emergency medical services diversion: A simulation model. Acad Emerg Med. 2008 Nov;15(11):1130–5.

[14] Holland LL, Smith LL, and Blick KE. Reducing laboratory turnaround time outliers can reduce emergency department length of stay: An 11-hospital study. Am J Clin Pathol. 2005 Nov;124(5):672–4.

[15] Falvo T, Grove L, Stachura R, and Zirkin W. The financial impact of ambulance diversions and patient elopements. Acad Emerg Med. 2007 Jan;14(1):58–62.

available on a timely basis. The denominator of the measure will only consist of those cases for which a Troponin test is ordered. We use field-testing to the extent it is feasible and practical in order to assess the completeness of the measure specifications in capturing numerators, denominators, and exclusions for chart abstracted measures. We will consider whether to field test of this measure in small hospitals as suggested by the commenter.

Comment: One commenter did not see the evidence linking the reporting of this measure with improved patient outcomes.

Response: The use of a Troponin test is important in the triage of patients with chest pain that do not have ST elevation. Use of the test facilitates decision making in the treatment of time sensitive conditions such as AMI. A timely report of Troponin results is crucial to being able to provide the most optimal care for the patient. The measure focuses on the timeliness of care as well as delays in ED management of this type of patients caused by delays in the availability of laboratory data.

Comment: Some commenters believed that Troponin is not an effective marker for the diagnosis of AMI, and for patients with a positive ST-elevation myocardial infarction (STEMI), their Troponin level will not affect physicians' decisions to transfer patients to bigger hospitals. Commenters indicated that the proposed 60-minute timeframe is unrealistic in the event that the Troponin test has to be repeated for verification. Commenters requested that CMS not adopt this measure due to concerns about the inconsistencies surrounding the use and interpretation of Troponin testing. Other commenters indicated that the lack of standardization in Troponin assays may yield different Troponin test results. One commenter cautioned that a Troponin test should not be the only criterion used to diagnose a patient with an AMI, and noted that other diagnostic criteria such as EKG results should be considered as well.

Response: We agree that the Troponin test is not necessary in the evaluation of a patient with an ST-elevation MI and clinical decision making in those cases is usually based on the electrocardiogram and clinical history. We agree with the commenter that other diagnostic measures should be performed in conjunction with Troponin which is only one piece of the diagnostic workup of patients with chest pain. Troponin assays may be negative for the first time or results may vary due to different calibrations. As mentioned earlier, Troponin assessment is not a requirement for management of acute myocardial infarction, and the measure we proposed, and are adopting in this final rule with comment period, does not implement a requirement to perform the test. The focus of this measure is on the timeliness of the receipt of the Troponin results and not on its use or interpretation.

Comment: Some commenters recommended the exclusion of patients who spend less than an hour in the hospital ED prior to transfer. Commenters also asked for clarification regarding the measurement of the 60-minute timeframe.

Response: We thank the commenters for the recommendation. We note that only patients who are transferred after one hour will be included in the denominator in the event the test is ordered.

Comment: A commenter asked for clarification of the target population to which this measure would apply. One commenter inquired if it is acceptable to give patients Point of Care Troponin instead of Troponin.

Response: The target population of this measure is ED patients with a diagnosis of AMI, and Angina, Acute Coronary Syndrome, or Chest Pain patients presumed to be cardiac in nature and have been prescribed a Troponin test. Point of Care Troponin is acceptable.

Comment: Some commenters urged CMS to delay the data collection start date from January 1, 2011 to July 1, 2011 discharges because otherwise, hospitals would only have 60 days from the publication of this final rule comment period to begin reporting data to CMS.

Response: We agree that the proposed collection start date may not allow sufficient time for hospitals to begin submitting data to CMS. Therefore, we have decided not to finalize the Troponin measure for the CY 2012 payment determination. Instead, we are adopting the measure for the CY 2013 annual payment update, which we believe will give hospitals sufficient time to prepare for the reporting of this measure. Hospitals will begin submitting data on the measure beginning with first quarter CY 2012 discharges, and hospitals will be required to submit data quarterly thereafter.

After consideration of the public comments we received, we are finalizing the "Troponin Results for Emergency Department Acute Myocardial Infarction (AMI) Patients or Chest Pain Patients (with *Probable Cardiac Chest Pain*) Received within 60 minutes of arrival" measure for the CY 2013 payment determination rather than the CY 2012 payment determination. Collection for the Troponin measure will begin with January 1, 2012 discharges.

In summary, for the CY 2012 payment determination, we are retaining the 11 existing HOP QDRP measures from the CY 2011 payment determination, adding one new structural measure, and adding 3 new claims-based imaging efficiency measures for a total of 15 measures. We will calculate the three imaging measures using Medicare claims from CY 2010. Submission of data regarding the new structural measure will begin in July 2011, with a reference period beginning January 1, 2011. Collection will occur using a Web-based collection tool available on the QualityNet Web site.

The complete list of 15 measures for the CY 2012 payment determination is shown below.

HOP QDRP Measurement Set To Be Used for the CY 2012 Payment Determination

OP–1: Median Time to Fibrinolysis.
OP–2: Fibrinolytic Therapy Received Within 30 Minutes.
OP–3: Median Time to Transfer to Another Facility for Acute Coronary Intervention.
OP–4: Aspirin at Arrival.
OP–5: Median Time to ECG.
OP–6: Timing of Antibiotic Prophylaxis.
OP–7: Prophylactic Antibiotic Selection for Surgical Patients.
OP–8: MRI Lumbar Spine for Low Back Pain.
OP–9: Mammography Follow-up Rates.
OP–10: Abdomen CT—Use of Contrast Material.
OP–11: Thorax CT—Use of Contrast Material.

HOP QDRP MEASUREMENT SET TO BE USED FOR THE CY 2012 PAYMENT DETERMINATION—Continued

OP–12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data *.
OP–13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery *.
OP–14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT) *.
OP–15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache *.

* New measure for the CY 2012 payment determination.

4. HOP QDRP Quality Measures for the CY 2013 Payment Determination

a. Retention of CY 2012 HOP QDRP Measures for the CY 2013 Payment Determination

In general, unless otherwise specified in the retirement section of a rule, we retain measures from one payment determination to another. In the CY 2011 OPPS/ASC proposed rule (75 FR 46366), for the CY 2013 payment determination, we proposed to retain all of the measures adopted for the CY 2012 payment determination. We invited public comment on this proposal for the CY 2013 payment determination.

Comment: One commenter strongly supported the proposed retention of CY 2012 HOP QDRP Measures for the CY 2013 payment determination.

Response: We thank the commenter for the support.

After consideration of the public comments we received, we have decided to adopt as final our proposal to retain the 15 HOP QDRP measures adopted for the CY 2012 payment determination, for the CY 2013 payment determination.

b. New Structural Measure for the CY 2013 Payment Determination

In the CY 2011 OPPS/ASC proposed rule (75 FR 46366), we proposed to add one structural measure to the HOP QDRP measurement set for the CY 2013 payment determination: Tracking Clinical Results Between Visits. EHRs enable providers to issue reminders when clinical results are not received within a predefined timeframe. This measure assesses the extent to which a provider uses a certified/qualified EHR system to track pending laboratory tests, diagnostic studies (including common preventive screenings) or patient referrals.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this structural measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed as part of an NQF Project entitled "National Voluntary Consensus Standards for Health IT" (NQF # 0491). Additionally, this measure was conditionally approved by the HQA in March of 2010.

Submission of this measure would begin with first quarter CY 2012 discharges to be submitted via the Web-based tool used to collect other structural measures, such as the registry participation structural measures for the Hospital Inpatient Quality Reporting Program. We invited comments on this proposal to add this new structural measure to the HOP QDRP measurement set and the submission process for the CY 2013 payment determination.

Comment: Some commenters noted that the proposed structural measure relates to an issue that is meaningful to the public, and that is important for both public reporting and payment policy. One commenter stated the measure is a useful quality metric, and asserted that the tracking of clinical results between visits improves the quality of care and reduces medical costs. Furthermore, some commenters recognized that the addition of this measure to the outpatient pay-for-reporting program and subsequent public reporting on the *Hospital Compare* Web site will accelerate hospitals' efforts to adopt EHRs to improve care coordination, patient safety, and outcomes.

Response: We appreciate the commenters' support and encouragement and agree with commenters that this measure would promote the adoption of EHR technology which will ultimately enhance the quality of care.

Comment: One commenter was concerned about the duplication of this measure with the meaningful use objectives set forth in the HITECH EHR Incentive Program final rule. Some commenters recommended maintaining this measure as a meaningful use HIT functionality objective under the HITECH EHR Incentive Program, and requested that CMS not adopt it for the HOP QDRP. Many commenters did not support this measure and stated that the measure is not evidence-based and has not been field-tested. Some commenters recommended using a "yes/no" format for the measure to reduce provider burden. Some commenters did not support this measure which they believed assesses HIT functionality rather than the quality of care provided. One commenter indicated that this measure is only warranted when EHRs are fully functional across hospital outpatient settings. Commenters suggested that this measure would be better suited as a physician office-based measure since physicians, not the hospitals, are the ones that order and track pending laboratory tests, diagnostic studies and patient referrals.

Response: We thank the commenters for the recommendations. We note that this measure does not duplicate any of the Stage 1 meaningful use objectives set forth in the HITECH EHR Incentive Program final rule. We note that this measure has NQF-time-limited endorsement and we plan to seek extension for the endorsement. The measure was also conditionally adopted by HQA in 2010. As suggested, we will adopt a "yes/no" format in the final specifications for this measure. This measure is a HIT functionality measure that can enhance the quality of care by helping providers to track clinical results between visits. The structural measure will provide CMS with information regarding the number of HOPDs that have acquired this HIT functionality. It will not penalize hospitals that do not have this capability.

Comment: Some commenters requested clarifications on the measure's targeted patient population. Commenters also asked for definitions of the numerator, denominator, inclusions, and exclusions, and the frequency of data collection.

Response: This measure population includes all patients who receive care at an HOPD. We will further clarify the requirements for this measure in the adaptation of the measure specifications for the HOPD setting.

After consideration of the public comments we received, we are finalizing this measure: Tracking

Clinical Results between Visits Using Certified/Qualified EHRs as Discrete Searchable Data for the CY 2013 annual payment update. HOPDs will be required to begin submitting data on this measure beginning in July 2012 with a reference period beginning January 1, 2012 via a Web-based tool available on the QualityNet Web site that is currently employed for the collection of structural measures for the Hospital Inpatient Quality Reporting Program.

c. New Chart-Abstracted Measures for the CY 2013 Payment Determination

In the CY 2011 OPPS/ASC proposed rule (75 FR 46367), we proposed to add six new chart-abstracted measures to the HOP QDRP measurement set for the CY 2013 payment determination.

The six new chart-abstracted measures we proposed for the CY 2013 payment determination are: (1) Median Time from ED Arrival to ED Departure for Discharged ED Patients, (2) Transition Record with Specified Elements Received by Discharged Patients, (3) Door to Diagnostic Evaluation by a Qualified Medical Professional, (4) ED–Median Time to Pain Management for Long Bone Fracture, (5) ED–Patient Left Before Being Seen, and (6) ED–Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Who Received Head CT Scan Interpretation Within 45 minutes of Arrival. The topics addressed by these measures include ED efficiency, Imaging Efficiency, and care coordination/transition for hospital outpatient departments. Many of these measures would expand the chart-abstraction population for the HOP QDRP measurement set beyond the current ED–AMI/Chest Pain, and Surgical Care patients for which we have currently adopted seven measures in the HOP QDRP measurement set. However, this population expansion would be occurring at a time when subsection (d) hospitals would begin collection of more global ED population measures for the Hospital Inpatient Quality Reporting Program. Thus, we have timed the expansion of the chart-abstracted measures for HOP QDRP to coincide with expansions that will be occurring for the Hospital Inpatient Quality Reporting Program in order to reduce the burden associated with expansion. We also anticipate that, in the future, these measures could be captured and submitted via EHRs, eliminating the chart abstraction burden associated with these measures.

- ED Measures

We received several general comments on the proposed ED measures.

Comment: Some commenters supported all the proposed chart-abstracted measures for the CY 2013 payment determination. Commenters believed the reporting of the ED measures would provide data needed to develop solutions to ED overcrowding and heavy emergency resource demand.

Response: We appreciate the commenters' support and we strive to develop measures to improve ED efficiency and quality of care.

Comment: Commenters suggested the chart-abstraction burden could be reduced if the patient population to which the measures apply is well-defined.

Response: We appreciate the suggestions. The ED measures apply to patients who present in and are treated at a hospital emergency department.

Comment: Commenters commended CMS' intent to align the time-sensitive ED measures with the meaningful use ED-focus quality measures under the HITECH EHR Incentive Program. Commenters recommended using EHR-compatible metrics to capture data for burden reduction. Several commenters recommended delaying the adoption of this measure until EHRs are fully functional in all hospital ED settings so that the data can be tracked electronically.

Response: We are committed to aligning ED quality measures in the HOP QDRP and in the HITECH EHR Incentive Program. As we stated, we anticipate that data on the proposed ED throughput measures will be able to be captured via an EHR-based collection tool in the future, and we expect that once the electronic data submission is possible, it will greatly reduce the burden on hospitals to submit data on these measures. However, we do not believe we should wait until EHR-specification has occurred and widespread adoption of EHRs has occurred in order to adopt these measures for the HOP QDRP.

Comment: Some commenters did not support the proposed ED measures as they did not believe the measures relate to clinical outcomes. One commenter believed that ED wait time is a process indicator rather than a quality indicator. Commenters believed that the proposed ED measures are simply arbitrary numbers that only measure how busy the ED is or how fast the care is delivered. Commenters stated that the proposed ED measures do not reflect the actual quality of care rendered; rather, the commenters believed that they reflect issues that are outside of the ED's control. Commenters voiced concerns that the measures may have unintended consequences resulting in hospitals providing faster care but not better care. Commenters were concerned that the introduction of the proposed ED measures will indirectly support the continued inappropriate use of EDs.

Response: We disagree with these comments. We believe that the proposed ED measures target the quality of care provided in the ED setting. Reducing the time patients spend in the ED can impact quality by increasing access to the ED for other patients needing emergent care. Reduced throughput time also increases the facility's capability to provide appropriate treatment and, as a result, contributes to better patient outcomes. Studies have already demonstrated that for a number of conditions, prolonged ED waiting times and delays results in patient harm and poor patient satisfaction. We intend to monitor the literature for evidence of any unintended consequences associated with these measures.

Comment: Commenters noted that the proposed ED measures did not take into consideration the ED's location, seasonal variations in ED use, the different socio-economic backgrounds of the ED patient population served by different hospitals, the misuse of EDs for primary care service, as well as other variables that are out of the ED's control. One commenter recommended that CMS use a risk-adjustment methodology for the ED measures to accommodate the multiple factors that can lead to ED overcrowding.

Response: Currently, we do not intend to risk-adjust the ED throughput measures. It is our belief that the public desires meaningful information about usual ED wait times, delays, and expectations for transition to inpatient care when needed. However, we will examine the data submitted on these measures to determine if stratification of the results based on hospital characteristics (such as ED volume, bed size, geographic location, or other factors) is needed.

Comment: A few commenters objected to the ED measures because they have not been field-tested, and commenters stated that field-testing is necessary to identify the potential challenges in data collection of the time elements.

Response: Many of these ED measures have undergone field testing in a project funded by the Robert Wood Johnson Foundation. A report can be found at *http://urgentmatters.org/media/file/*

UM%20LN%20II%20-%202nd%20IB%20-%20FINAL.pdf.

Comment: Commenters noted that data collection will be challenging as the time elements that the proposed measures assess are generally not part of a patient's health record, but instead are more often part of a patient tracking system used by the ED. Some commenters questioned if random sampling is acceptable. Other commenters noted that random sampling may miss some "mean time" and "median time" outliers.

Response: We are aware of the amount of chart-abstraction burden for the ED measures which target all patients seen in the ED. While the electronic specification for these measures is under development, specification for sampling is being developed to assist hospital EDs in chart-abstraction in the interim.

Commenters also made specific comments on the proposed ED measures.

• Median Time From ED Arrival to ED Departure for Discharged ED Patients

This measure, which was listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641), addresses ED efficiency in the form of the median time from ED arrival to time of departure from the ED for patients discharged from the ED (also known as ED throughput). Reducing the time patients spend in the ED can improve the quality of care. Reducing this time potentially improves access for other patients needing emergency care and increases hospitals' capability to provide additional treatment as necessary. Overcrowding and heavy emergency resource demand have led to a number of problems, including ambulance refusals, prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes. ED crowding may result in delays in the administration of medication such as antibiotics for pneumonia and has been associated with perceptions of delayed emergency care. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this chart-abstracted measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed in 2009 (NQF #0496) as part of an NQF project entitled "National Voluntary Consensus Standards for Emergency Care." Additionally, this measure was conditionally approved by the HQA in March of 2010.

Comment: Some commenters expressed strong support for this ED throughput measure and recommended its inclusion in the HOP QDRP. Some commenters stated that a measure assessing delays in patient care is important as providers experience a growth in demand for ED services. Commenters believed that public reporting of the measure will encourage HOPDs to make improvements, such as reducing overcrowding and improving patient access to EDs, and, as a result, will increase the quality of care they deliver.

Some commenters stated that based on their experience, the information provided by the measure was very important and useful to a hospital's quality improvement program. Commenters also stated that they were aware of hospitals that already collected this information and that, to their knowledge, these hospitals had no difficulty in collecting it.

Response: We thank the commenters for their supportive statements. We also appreciate the commenters' insightful experience, and we are pleased to learn that commenters believe this measure addresses the issue of timely emergency department care and the role it plays in reducing ED overcrowding.

Comment: A few commenters indicated it will be overly burdensome for hospitals to collect data on a patient's arrival time in the ED because they will have to note the arrival time for each patient. Many commenters indicated that, as currently structured, the measure includes the time spent receiving care in the ED in addition to the time spent waiting in the ED. These commenters indicated that the time spent receiving care in the ED should not be counted against the hospital, as it does not represent a delay in care. The commenters suggested that CMS modify the measure so that it reflects only the time spent waiting in the ED to receive care.

Response: We do not agree that it will be overly burdensome for hospitals to submit data on this measure because hospitals routinely collect the key information needed to calculate the median time (ED arrival date and time and ED departure date and time) for each emergency department patient. We also note that ED arrival times must already be reported by hospitals under the Hospital Inpatient Quality Reporting Program for conditions such as acute myocardial infarction and pneumonia. We believe that revising the measure as suggested by the commenters to exclude active treatment times would actually increase the burden on hospitals because they would be required to accurately track and collect all the wait time that a patient spent in the ED not receiving care.

Comment: A few commenters stated that the proposed ED throughput measure does not take into consideration typical ED operating principles such as serving patients with the most urgent needs first, or other factors that are out of an ED's control, such as the fact that teaching hospitals usually treat sicker patients. One commenter recommended stratifying the reporting results by type of hospital so as to obtain a more appropriate comparison among institutions. Another commenter requested exclusions for psychiatric or placement issues, age and co-morbidities. Alternatively, some commenters suggested that the proposed "Door to Diagnostic Evaluation by a Qualified Medical Professional" measure is a more appropriate measure to determine ED efficiency and throughput.

Response: We agree that the Door to Diagnostic Evaluation is an appropriate measurement of time to assessment. Nonetheless, we also believe that the proposed median time from arrival to departure measure provides valuable information regarding the total time a patient spent in the ED, starting from arrival time at the ED to the time the patient is discharged. The public desires meaningful information about usual wait times, delays, and expectations for transition time to inpatient care. As we have stated, we believe that prolonged ED visits and waiting times could cause patient harm and increase the likelihood that the hospital's ED will need to divert potential patients elsewhere for care. We will, however, examine the measure results to determine whether alternative stratification reporting based on hospital characteristics (ED volume, bed size, geographic location, etc.) is necessary.

After consideration of the public comments we received, we are finalizing the Median Time from ED Arrival to ED Departure for Discharged ED Patients measure for the CY 2013 payment determination.

• Transition Record With Specified Elements Received by Discharged Patients

This chart-abstracted measure assesses the percentage of patients, regardless of age, discharged from an ED to ambulatory care or home healthcare, or their caregiver(s) at home, who received a transition record at the time of ED discharge including at a minimum, the following elements: Major procedures and tests performed during the ED visit; principal diagnosis at discharge or chief complaint; patient instructions; plan for follow-up care (or statement that none is required)—including primary physician, other health care professional, or site designated for follow-up care; and list of new medications and changes to continued medications that patient should take after ED discharge, with the quantity prescribed and/or dispensed (or intended duration) and instructions for each. Transitions of care are a weakness in maintaining continuity of care and proper adherence/compliance with follow-up instructions. Hand-offs between settings should be accompanied by clear instructions for medications and follow-up care. Information should be provided about the care delivered while in each setting, and for what reasons, not only for the benefit of the patient and their caregivers, but for practitioners that will be following up with the patient after they leave an acute care setting.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed by the NQF as part of a Project entitled "Endorsing Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination" (NQF #0649). This measure was conditionally approved by the HQA in March of 2010.

Comment: Some commenters strongly supported this measure and noted that the measure is scientifically valid and well-specified, and will fill a significant gap in the current health-care system which does not have standardized data elements in patient's health records.

Response: We thank the commenters for their support.

Comment: Some commenters noted that the measure is purely a documentation measure rather than a measure for accountability and the true quality of care. Commenters asked for clarification of the target patient population for this measure.

Response: Although the measure assesses whether certain documentation was provided to discharged patients, its purpose is to facilitate a continuity of care and a seamless transition when a patient is discharged from an ED to home or home care setting. The target patient population for this measure is the discharged patients from a hospital ED to home or a home care setting.

Comment: Several commenters stated their belief that this measure is overly burdensome as new data elements may have to be included in patients' ED transition records, and ED patient transfer procedures may have to be modified. One commenter suggested that CMS use a consensus-based process to develop standardized data elements for this measure. One commenter recommended that CMS field-test the measure for feasibility.

Response: Standardized data elements have been developed and field-tested for this measure. We believe that the use of standardized transition records and data elements across hospital outpatient department settings actually increase the efficiency of the transition and discharge process and allow hospitals to pre-plan transition procedures. We also believe that the use of standardized transition records will make it easier for hospitals to find the information when conducting chart abstraction, therefore minimizing the burden.

Comment: Some commenters were concerned that HOPDs may be held accountable for the omission of data elements in a transition record that they have no control over, for instance, a physician's medication instructions for medication changes (this information may not be available to the ED), a patient's adherence to discharge instructions, and whether a patient followed up with doctor's appointments. The commenter recommended removing the data elements of "(medications) quantity prescribed and/or dispensed" from the measure specifications.

Response: We hope that documentation practices will improve so that complete information will be available in patients' discharge records. We believe that documentation of medications prescribed as well as dosages are important parameters for transitional care and we do not agree that the documentation of this element should be removed. We encourage hospitals to examine their ED discharge procedures to ensure that discharged patients receive a copy of the transition records with the specific data elements required under the measure.

After consideration of the public comments we received, we are finalizing the Transition Record with Specified Elements Received by Discharged Patients measure for the CY 2013 payment determination.

• Door to Diagnostic Evaluation by a Qualified Medical Professional (Door to Provider)

This measure assesses mean time between patient presentation to the ED and the first moment the patient is seen by a person who can initiate a diagnostic evaluation or therapeutic plan (for example, medical student, resident, or nurse practitioner; not including triage personnel). Long wait times in the ED before diagnosis increases the likelihood that someone will leave the ED without treatment for a serious condition, and can worsen the severity of the condition with which they presented.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it gained NQF endorsement as part of the project entitled "National Voluntary Consensus Standards for Emergency Care" (NQF #0498). This measure was conditionally approved by the HQA in March of 2010.

Comment: A few commenters supported this measure and believed the measure helps to expedite the triage, evaluation, and discharge process especially for patients who present with non-emergent conditions.

Response: We thank the commenters for the supportive statements.

Comment: Some commenters noted that current technical specifications for this measure exclude registered nurses as qualified medical professionals. These commenters supported the adoption of this measure if the definition of "qualified medical professional' is expanded to include a

registered nurse, advanced practice nurse, resident or medical student.

Response: We thank the commenters for the suggestions and will take them into consideration.

Comment: Some commenters recommended CMS risk-adjust this measure to distinguish the average wait time spent by urgent versus non-urgent patients, based on the belief that non-urgent patients who present in hospital EDs or trauma centers usually have longer wait times for evaluation than critically ill or injured patients. One commenter recommended tracking the patient's triage level to distinguish urgent care from non-urgent care.

Response: We thank the commenters for the recommendation. There are no plans for risk-adjustment for this measure at the time because we expect the measure metric will provide valuable information regarding the timeliness of assessment regardless of what condition the patient presents.

Comment: One commenter noted that the door to evaluation time is rarely captured electronically in the ED and there are still many EDs that do not use EHR technology.

Response: We believe that many EDs routinely electronically document door to evaluation time. For facilities that have not done so, we encourage them to start documenting it. There are no requirements for EDs to use EHR technology. However, because of the efficiency benefit from EHR technology, we anticipate there will be a widespread utilization of EHR technology in the future.

Comment: One commenter expressed concerns that the structure of the measure may stifle innovation in ED staffing by measuring hospitals on the time it takes for a patient to reach only a subset of all the staff that provide care to patients in EDs.

Response: We acknowledge that ED care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient. We also acknowledge that this measure assesses one aspect of ED quality. However, we do not believe that implementation of this measure stifles innovation in ED staffing, because the level of coordination and efficiency of the aforementioned processes impacts performance on this measure.

After consideration of the public comments we received, we are finalizing the Door to Diagnostic Evaluation by a Qualified Medical Professional (Door to Provider) measure for the CY 2013 payment determination.

- ED-Median Time to Pain Management for Long Bone Fracture

This chart-abstracted measure addresses the topic of efficient pain management in the ED, and is currently being reviewed by NQF. Pain management in patients with long bone fractures is currently undertreated in emergency departments.[16] Patients with bone fractures are many times not given pain medication as part of treatment regimens.[17] When standards are implemented for pain management of these patients, treatment for pain improves.[18]

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it underwent development through a consensus-based measure development process involving stakeholder input. In the proposed rule we stated that we anticipated that this measure would be endorsed by the NQF.

Comment: A few commenters supported the adoption of this measure because it measures a process that affects quality of care and is patient centered. Some commenters requested that we adopt more pain management measures for long bone fracture as part of a larger framework for pain management in the ED setting. One commenter requested guidelines for the "median time" (when the patient arrives at the facility or when the diagnosis of a long bone fracture is made).

Response: We thank the commenters for the support and suggestions and we will consider them in future measure development. Currently the "median time" calculation is based on arrival time and time to administration of medication.

Comment: Several commenters did not support this measure because it is not NQF-endorsed. Commenters requested the evidence that prompted the need for this measure. One commenter stated this measure did not rise to the top in significance as a singular measure and stated that it is not appropriate for public reporting.

Response: Although we generally prefer to adopt NQF-endorsed measures for CMS quality reporting programs, we have stated that consensus among affected parties can be achieved in other ways including consensus achieved during the measure development process; consensus shown through broad acceptance and use of measures; and consensus through public comment. We also note that section 1833(t)(17) of the Act does not require that each measure we adopt for the HOP QDRP be endorsed by a national consensus building entity, or by the NQF specifically. Over the years, we have recognized that pain management in ED patients with long bone fracture is inadequate and that treatment disparities for this condition exist among EDs. We anticipate the measure will serve to facilitate improvements in pain management for this patient population in EDs. This measure is recommended for endorsement by the NQF Steering Committee, and we believe that it meets the requirement that the measure reflect consensus among affected parties.

Comment: One commenter noted the measure does not take into account whether the level of pain warrants pain medication, or whether the pain is relieved with the medication given.

Response: The measure is calculated based solely on the timeliness of pain medication administration and not on the level of pain. The final measure specifications for the numerator will exclude patients who are offered medication but refuse it.

After consideration of the public comments we received, we are finalizing the ED—Median Time to Pain Management for Long Bone Fracture measure for the CY 2013 payment determination.

- ED-Patient Left Without Being Seen

This measure is the percentage of all patients leaving an ED who were not seen by a provider (for example, medical student, resident, nurse practitioner). Although we stated in the CY 2011 OPPS/ASC proposed rule (75

[16] Ritsema, T.S., Kelen, G.D., Pronovost, R.J., and Pham, J.C.: The national trend in quality of emergency department pain management of long bone fractures. Acad Emerg Med. 2007 Feb 14; 14(2):163–9.

[17] Brown, J.C., Klein, E.J., Lewis, C.W., Johnston, B.D., and Cummings, P.: Emergency department analgesia for fracture pain. Ann Emerg Med. 2003 Aug;42(2):197–205.

[18] Titler, M.G., Herr, K., Brooks, J.M., Xie, X.J., Ardery, G., Schilling, M.L., Marsh, J.L., Everett, L.Q., Clark, W.R: Translating research into practice intervention improves management of acute pain in older hip fracture patients. *Health Serv Res. 2009*;44(1),264–87.

FR 46368) that "this measure is the sum of all patients leaving an ED who were not seen by a provider," the technical specifications for the measure, which were publicly available at the time we issued the proposed rule, state that this measure is calculated based on a percentage. Therefore, we are clarifying that this measure looks at percentages. A patient leaving before being seen is an indicator of emergency department overcrowding.[19] Patients who leave before being seen may not receive appropriate medical care and this lack of care may result in adverse outcomes.[20] National estimates for patients who leave before being seen by a provider average 1.9 percent.[21]

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed by the NQF (NQF # 0499) as part of the National Voluntary Consensus Standards for Emergency Care.

Comment: Some commenters supported this measure because it is an indicator of efficiency in the ED and they noted the measure appears to be scientifically valid in providing valuable information to hospitals to assess their ability to provide quality care to all patients in their EDs in a timely manner.

Some commenters shared that these measure metrics are very important and useful to a hospital's quality improvement program. Commenters stated that hospitals participating in the field test reported no difficulty in collecting the data for the measure.

Response: We thank the commenters for their supportive statements. We also appreciate the commenters' insightful experience and we are pleased to learn that hospitals acknowledged this measure addresses the issue of timely emergency department care and the role it plays in reducing ED overcrowding.

Comment: Some commenters noted that hospitals have had difficulty collecting the relevant information needed for this measure due to insufficient record-keeping, such as the lack of documentation noting the patient departure time from the ED. Commenters requested more explicit, standardized definitions for time-sensitive terms like "left without being seen" (before or after triage). One commenter noted that generally, only a very small percentage of patients leave without being seen by ED staff and these patients may have been overly impatient. At many facilities, no medical record is created when a patient leaves prior to registration, and commenters stated that ED staff must be educated regarding what documentation is necessary to comply with this measure.

Response: We will provide detailed specifications of the measure in the HOPD Specifications Manual to facilitate hospital data collection. We agree that hospitals need to educate ED staff to ensure that patient arrival and departure times are recorded correctly.

After consideration of the public comments we received, we are finalizing the ED-Patient Left Without Being Seen measure for the CY 2013 payment determination.

- ED-Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Who Received Head CT Scan Interpretation Within 45 Minutes of Arrival

This measure assesses whether head CT scan results for acute ischemic stroke or hemorrhagic stroke patients who received head CT scans in the ED were interpreted within 45 minutes of arrival. This chart-abstracted measure is currently under NQF review. Improved access to diagnostics assists clinicians in decision making. Delayed diagnostic imaging and laboratory reports are expected to slow down the clinical decision making process and subsequently increase the length of stay in the ED. In addition to helping reduce the length of stay in the ED, decreasing radiology report turnaround times can improve care throughout the facility. Timely diagnostic imaging can enhance decision making capabilities for patient treatment plans because timely diagnostic imaging is available.[22] The Food and Drug Administration (FDA) approved the use of tissue plasminogen activator (t-PA) for treatment of acute ischemic strokes, which comprise 87 percent of stokes, when given within three hours of stroke symptom onset.[23] [24] Because of the therapeutic time window for treatment possibilities, timely completion and results of the CT scan are imperative for timely clinical decision making and favorable outcomes. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring the quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because this measure underwent development through a consensus-based measure development process involving stakeholder input. We anticipate that this measure will be endorsed by the NQF.

We proposed that the submission of the new chart-abstracted measures for the CY 2013 payment determination would begin with first quarter 2012 discharges, and data would be submitted quarterly, as with all other chart-abstracted measures. We invited comments on our proposal to add these new measures to the HOP QDRP measurement set and on the submission process for the CY 2013 payment determination.

Comment: Some commenters supported the measure and agreed with CMS that timely completion of CT scan results are imperative for the treating neurologist to make timely clinical decisions. One commenter noted that the measure has been modified by the measure developer to include MRI in addition to CT.

Response: We thank the commenters for the supportive comments and for the suggestion. We will consider whether MRI should be added to the measure in

[19] United States General Accounting Office. Hospital emergency departments: Crowded conditions vary among hospitals and communities. Publication GAO–03–460, 2003.

[20] Rowe, B.H., Channan, P., Bullard, M., Blitz, S., Saunders, L.D., Rosychuk, R.J., Lari, H., Craig, W.R., Holroyd, B.R.: Characteristics of patients who leave emergency departments without being seen. Acad Emerg Med. 2006 Aug;13(8):848–52.

[21] McCaig, L.F., Nawar, E.W.: National hospital ambulatory medical care survey: 2004 Emergency department summary. Adv Data. 2006 Jun 23;(372):1–29.

[22] Marquez L.O. Improving medical imaging report turnaround times. Radiol Mange. 2005 Jan.–Feb;27(1):34–7.

[23] National Stroke Association. STROKE the First Hours Guidelines for Acute Treatment, 2000.

[24] The ATLANTIS, ECASS, and NINDS rt-PA Study Group Investigators. Association of Outcome with early stroke treatment: pooled analysis of ATLANTIS, ECASS, and NINDS rt-PA stroke Trials. Lancet 2004;363:768–774.

our process for ongoing maintenance of the measure.

Comment: Many commenters requested clarifications on: (1) Whether the measure requires the actual CT scan report to be present in the medical record within 45 minutes of arrival (or will verbal communication between caregivers that is documented in the medical record suffice); and (2) the definition of arrival time (is it the time the patient was registered, the time of first clinical staff discussion, or the time the physician first saw the patient). Some commenters were concerned about the challenge for hospitals to consistently collect the information necessary to determine whether patients are arriving at the ED within two hours of the onset of symptoms, as well as collect information on the timing of when the scan was interpreted. One commenter expressed concerns that this measure may inadvertently encourage patient referral to a CT scan even before a full clinical evaluation occurs. The commenter noted that frequently, the Neurology Stroke Team reviews and makes decisions upon CT scans before the scan is officially read and documented by the radiologist.

Response: Current specifications require the earliest documented time, which include verbal documentation of interpretation. We intend to provide detailed specifications regarding the collection of arrival time for the measure in the HOPD Specifications Manual.

Comment: One commenter suggested that a measure that assesses the time from decision (order) to interpretation (preliminary result) would be a better marker of quality of care in the ED. A few commenters recommended harmonizing the measure with the set of NQF-endorsed stroke care measures.

Response: We considered the option suggested by the commenter, but ultimately made the decision to align the measure with the existing ED measures that have been endorsed by the NQF so that all of the measures for the ED utilize consistent definitions. We thank the commenters for the recommendation.

After consideration of the public comments we received, we are finalizing the ED-Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Who Received Head CT Scan Interpretation within 45 minutes of Arrival measure for the CY 2013 payment determination.

In summary, after consideration of the public comments we received, we are finalizing for the CY 2013 payment determination: (1) The 15 quality measures that we are adopting in this final rule with comment period for the CY 2012 payment determination; (2) one new structural measure (Tracking Clinical Results Between Visits); (3) six new chart-abstracted measures on the topics of HOPD care transitions and ED efficiency; and (4) one new chart-abstracted measure that we originally proposed to adopt for the CY 2012 payment determination (Troponin Results for Emergency Department AMI Patients or Chest Pain Patients (with probable cardiac chest pain) Received Within 60 Minutes of Arrival), for a total of 23 measures for the CY 2013 payment determination. As stated above, hospitals will be required to begin submitting data on the new structural measure via a Web-based tool on the QualityNet Web site in July 2012 for the period January 1, 2012 through June 2012. The submission of data for the new chart-abstracted measures for the CY 2013 payment determination will be due in August 2012.

The complete list of 23 measures for the CY 2013 payment determination is shown below.

HOP QDRP Measurement Set To Be Used for the CY 2013 Payment Determination

OP–1: Median Time to Fibrinolysis
OP–2: Fibrinolytic Therapy Received Within 30 Minutes
OP–3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP–4: Aspirin at Arrival
OP–5: Median Time to ECG
OP–6: Timing of Antibiotic Prophylaxis
OP–7: Prophylactic Antibiotic Selection for Surgical Patients
OP–8: MRI Lumbar Spine for Low Back Pain
OP–9: Mammography Follow-up Rates
OP–10: Abdomen CT—Use of Contrast Material
OP–11: Thorax CT—Use of Contrast Material
OP–12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data*
OP–13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery*
OP–14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)*
OP–15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
OP–16: Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) Received Within 60 minutes of Arrival**
OP–17: Tracking Clinical Results between Visits**
OP–18: Median Time from ED Arrival to ED Departure for Discharged ED Patients**
OP–19: Transition Record with Specified Elements Received by Discharged Patients**
OP–20: Door to Diagnostic Evaluation by a Qualified Medical Professional**
OP–21: ED-Median Time to Pain Management for Long Bone Fracture **
OP–22: ED-Patient Left Before Being Seen**
OP–23: ED-Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival **

* New measure for the CY 2012 payment determination.
** New measure for the CY 2013 payment determination.

5. HOP QDRP Quality Measures for the CY 2014 Payment Determination

a. Retention of CY 2013 HOP QDRP Measures for the CY 2014 Payment Determination

In general, unless otherwise specified in the retirement section of a rule, we retain measures from one payment determination to another. In the CY 2011 OPPS/ASC proposed rule (75 FR 46370), for the CY 2014 payment determination, we proposed to retain all of the measures adopted for the CY 2013 payment determination. We invited comment on this proposal.

We did not receive any comments. Accordingly, we are finalizing our proposal to retain the 23 CY 2013 HOP QDRP measures for the CY 2014 payment determination.

b. New Chart-Abstracted Measures for the CY 2014 Payment Determination

In the CY 2011 OPPS/ASC proposed rule (75 FR 46370 through 46372), we proposed to adopt six new chart-abstracted measures for the CY 2014 payment determination. Five of the six measures are Diabetes Care measures for HOPDs, and one measure is an additional imaging efficiency measure. The six measures we proposed for the CY 2014 payment determination are: (1) Hemoglobin A1c Poor Control in Diabetic Patients; (2) Low Density Lipoprotein (LDL–C) Control in Diabetic Patients; (3) High Blood Pressure Control in Diabetic Patients; (4) Dilated Eye Exam in Diabetic Patients; (5) Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients; and (6) Exposure Time Reported for Procedures Using Fluoroscopy. We proposed that submission of these measures for the CY 2014 payment determination begin with the first quarter CY 2013 discharges. These measures are discussed below.

• Diabetes Care Measures

Comment: A few commenters appreciated CMS' proposal to add diabetes care measures to the HOP QDRP because they will enhance the quality of care provided to the growing diabetic patient population in the hospital outpatient setting. One commenter suggested reporting the diabetes care measures as a single composite measure of quality of diabetes care so that hospitals can identify improvement opportunities. Some commenters requested clarification on the diabetes care measure specifications in terms of chart-abstracted data elements and current physician CPT–II coding requirements. Commenters noted that the PQRI program is already collecting data for similar measures. Commenters provided recommendations to reduce the chart-abstraction burden including harmonizing the measures for the physician and HOPD settings, developing EHR-compatible metrics, and collecting data from diabetes registries. Many commenters believed that the five diabetes care measures do not assess the quality of care provided by HOPDs, because the care furnished in that setting is fragmented and episodic, and stated that the measures more appropriately assessed the care provided by physician practices. Some commenters suggested that CMS should limit the targeted patient population to ambulatory care clinics only so that hospitals would not be unduly burdened with chart-abstraction.

Several commenters expressed concerns about the administrative and financial burden associated with chart-abstracted quality measures while the industry is transitioning into ICD–10 codes, adopting EHRs to meet the meaningful use objectives under the EHR Incentive Program, and preparing to comply with the quality provisions in the Affordable Care Act. Commenters indicated that CMS should delay the adoption of the chart-abstracted diabetes care measures.

Response: We appreciate the commenters' recognition of the value of the diabetes care measures. The diabetes care measures apply to hospital outpatient departments that provide primary care services, and we are aware that many hospital outpatient departments provide ongoing primary care for patients. Thus, we disagree with the comments questioning the appropriateness of applying the diabetes measures to hospital outpatient departments. However, we acknowledge the challenges faced by hospitals amid implementation of various programs.

We are currently refining the chart abstracted numerator definitions for these measures and expect to include them in an upcoming HOPD Specification Manual release. For this reason, we are deferring our finalization of these 5 diabetes care measures in this final rule with comment period, but intend to propose these measures again in the CY 2012 OPPS/ASC proposed rule for the CY 2014 payment determination. We also intend to develop electronic specifications for these measures so that they can be captured and reported by EHRs, which we believe will reduce the burden associated with chart abstraction. We thank the commenters for the suggestions and input on the measures and we will take them into consideration as we further refine the specifications for these 5 measures.

• Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetic Patients

This NQF-endorsed measure (NQF #0059) measures the percentage of adult patients with diabetes aged 18–75 years with most recent HgA1c level greater than 9 percent (poor control). Glycosylated hemoglobin (HgA1c) assay measures average blood glucose over the preceding two to three months, rather than just one point in time. HgA1c values vary less than fasting glucose values and give clinicians a better integrated view of the patient's average blood sugar over time. High HgA1c is a more reliable indicator of chronic high blood sugar. Lowered HgA1c levels are associated with reduced microvascular and neuropathic complications of diabetes.

In general, diabetes mellitus is a chronic disease that impacts the lives of a large portion of the population and consumes a significant amount of U.S. healthcare dollars. With the prevalence of diabetes in the Medicare-eligible population expected to double, costs are expected to increase almost fourfold to $171 million.[25] Uncontrolled diabetes often leads to biochemical imbalances that can lead to acute life-threatening events, such as diabetic ketoacidosis and hyperosmolar, or nonketotic, coma. In patients with insulin-dependent diabetes, the risk of development or progression of retinopathy, nephropathy, and neuropathy can be reduced by 50 to 75 percent by intensive outpatient treatment of hyperglycemia compared to conventional treatment. Early treatment may help slow or halt the progression of diabetic complications, and following the guidelines for screening may assist those patients with no outward sign of diabetic complications to be identified earlier through regular screening tests. HgA1c should be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals.[26] Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect

[25] Huang, E.S., Basu, A., O'Grady, M., Capretta, J.C.: Projecting the future diabetes population size and related costs for the U.S. Diabetes Care. 2009;32(12):2225–29.

[26] The American Association of Clinical Endocrinologists Medical Guidelines for the Management of Diabetes Mellitus: The AACE System of Intensive Diabetes Self-Management—2002 Update.

consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, it has been endorsed by the NQF.

Comment: One commenter agreed that this is a good measure for patients with diabetes but recommended the threshold for poor control of diabetes be lowered to mean a most recent HgA1c level of greater than 7 percent.

Response: We will take the recommendation into consideration in our measure refinement process.

As we stated above, we are not finalizing the Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetic Patients measure in this final rule with comment period, but we intend to propose this measure again in the CY 2012 OPPS/ASC proposed rule for the CY 2014 payment determination.

• Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetic Patients

This NQF-endorsed measure (NQF #0064) measures the percentage of adult patients with diabetes aged 18–75 years whose most recent LDL–C test result during the measurement year was < 100 mg/dl. LDL–C measures the development of atherosclerotic plague which increases cardiac events risks for diabetic patients whose heart disease death rates are about two to four times higher than non-diabetics.[27] Improved dyslipidemia management helps to mitigate the risk for cardiovascular disease. Lipid-lowering therapy for diabetics has been a consistent recommendation in several guidelines, prompted by randomized trials supporting statin therapy to lower the risk of cardiovascular involvement for this population. Despite the evidence basis and guideline support, only a minority of patients with diabetes are prescribed statin treatment or achieve target LDL–C goals.[28] Early treatment may help slow or halt the progression of cardiovascular disease and impact the quality of the life of the diabetic patient, affecting the patient's life expectancy and decreasing costs involved in treating diabetic complications. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, it has been endorsed by the NQF. We also note that this measure was listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641).

Comment: One commenter supported this measure.

Response: We thank the commenter for the support.

After consideration of the public comments we received, we are not finalizing the Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetic Patients measure in this final rule with comment period, but intend to propose this measure again in the CY 2012 OPPS/ASC proposed rule for the CY 2014 payment determination.

• Diabetes Mellitus: High Blood Pressure Control in Diabetic Patients

This NQF-endorsed measure (NQF #0061) measures the percentage of patients visits with blood pressure measurement recorded among all patients visits aged > 18 years with diagnosed hypertension. Blood pressure control reduces the risk of cardiovascular disease and microvascular complications in patients with diabetes. Most importantly, early treatment of high blood pressure may help slow or halt the progression of kidney involvement and damage.[29] Well-controlled blood pressure impacts the quality of the life of the diabetic patient, affects the patient's life expectancy, and decreases the costs involved in treating diabetic complications. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, it has been endorsed by the NQF.

Comment: A few commenters supported the measure and noted that the target blood pressure has become controversial based on the recent ACCORD trials. One commenter suggested lowering the threshold to 130/80 mm/Hg as recommended by the American Diabetes Association and the American Association of Clinical Endocrinologists. Another commenter recommended a target blood pressure of 140/80 mm/Hg.

Response: We thank the commenters for the support and input and will take it into consideration in the measure refinement process.

After consideration of the public comments we received, we are not finalizing the Diabetes Mellitus: High Blood Pressure Control in Diabetic Patients measure in this final rule with comment period, but intend to propose this measure again in the CY 2012 OPPS/ASC proposed rule for the CY 2014 payment determination.

• Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients

This NQF-endorsed measure (NQF #0055) measures the percentage of adult patients with diabetes age 18 to 75 years who received a dilated eye exam or seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist, or imaging to verify diagnosis from stereoscopic photos during the reporting year, or during the prior year, if the patient is at low risk for retinopathy. A patient is considered low risk if the patient has no evidence of retinopathy in the prior year. A dilated eye exam helps to detect the risk for vision-threatening diabetic retinopathy which is prevalent among people with diabetes. Data from the 2007 National Diabetes Fact Sheet (using the most recent year of available data) shows that diabetic retinopathy causes up to 24,000 new cases of blindness each year.[30] However, dilated eye exams for diabetic

[27] American Diabetes Association. Standards of medical care in diabetes. Diabetes Care. 2007 Jan;30 (Suppl 1):S8–15.

[28] Das, S.R., Vaeth, P.A., Stanek, H.G., de Lemos, J.A., Dobbins, R.L., McGuire, D.K.: Increased cardiovascular risk associated with diabetes in Dallas County. Am Heart J 2006;151:1087–93.

[29] Centers for Disease Control and Prevention. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2007. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.

[30] Centers for Disease Control and Prevention. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2007. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.

patients can prevent retinopathy through early detection.[31]

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, this measure has been endorsed by the NQF. We note that this measure was listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641).

Comment: One commenter recommended adopting the American Diabetes Association Standards of Care for annual dilated eye examination. Two commenters suggested that this measure should be a claim-based measure because CMS can access the billings of the ophthalmologist who most likely provides the dilated eye exam to diabetic patients.

Response: We thank the commenters for the input and will take the feedback into consideration in the measure refinement process.

After consideration of the public comments we received, we are not finalizing the Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients measure in this final rule with comment period, but intend to propose this measure again in the CY 2012 OPPS/ASC proposed rule for the CY 2014 payment determination.

• Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

This NQF-endorsed measure (NQF #0062) measures the percentage of adult diabetic patients ages 18–75 years with at least one test for microalbumin during the measurement year or who had evidence of medical attention for existing nephropathy (diagnosis of nephropathy or documentation of microalbuminuria or albuminuria). Urine screening for microalbumin detects abnormal amount of protein albumin leaks in the urine by the capillaries of the kidney. High levels of blood sugar in uncontrolled diabetes can cause damage to the capillaries in the kidneys. Early urine screenings for microalbumin may prevent kidney disease from worsening to end-stage renal disease (ESRD). Diabetics accounted for 44 percent of new cases of kidney disease. In 2005, a total of 178,689 diabetics with ESRD were on dialysis or received a kidney transplant in the United States and Puerto Rico.[32] In 2009, MedPAC reported costs for the 330,000 Medicare recipients receiving dialysis treatment for ESRD at over 8 billion dollars.[33]

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, it has been endorsed by the NQF. We also note that this measure was listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641).

Comment: Two commenters supported this measure but suggested that it be a claim-based measure.

Response: We thank the commenters for the suggestion.

Comment: Some commenters requested clarification on the diabetes care specifications in regards to the interface of the current physician CPT–II code data and the chart-abstracted data.

Response: We thank the commenters for the input and will take it into consideration in the measure refinement process.

After consideration of the public comments we received, we are not finalizing the Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients measure in this final rule with comment period, but intend to propose this measure again in the CY 2012 OPPS/ASC proposed rule for the CY 2014 payment determination.

• Exposure Time Reported for Procedures Using Fluoroscopy

This measure documents the percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time, an important measure for the HOPD setting. This measure is currently specified for physician level data collection through the PQRI program (74 FR 61825), and can be used for the hospital outpatient facility level. This measure evaluates the documentation of radiation exposure or radiation time during fluoroscopy. Data suggests that the lifetime risk for cancer can be increased, albeit by a small amount, with frequent or repeated exposure to ionizing radiation, including procedures using fluoroscopy.[34] To monitor these long term effects, the exposure time or radiation dose that a patient receives as a result of the procedure should be measured and recorded in the patient's record. The ACR encourages practices to record actual fluoroscopy time for all fluoroscopic procedures. The fluoroscopy time for various procedures (for example, upper gastrointestinal, or pediatric voiding cystourethrography) should then be compared with benchmark figures.[35] [36] The National Cancer Institute recommends measuring and recording patient radiation dose, fluoroscopy time and that additional measures be developed regarding dose area product, cumulative dose, and skin dose.[37] Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable,

[31] American Diabetes Association. Standards of medical care in diabetes. Diabetes Care. 2007 Jan;30 (Suppl 1):S8–15.

[32] Centers for Disease Control and Prevention. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2007. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.

[33] MedPAC. Outpatient dialysis service: assessing payment adequacy and updating payments. Report to the Congress: Medicare payment policy. 2009 Mar;131–56.

[34] National Cancer Institute (NCI), The Society for Pediatric Radiology (SPR). Brochure: Radiation & pediatric computed tomography. A guide for health care providers. 2002. Available at; *http://www/cancer.gov/cancertopics/cause/radiation-risks-pediatric-CT.pdf*.

[35] Amis E Jr, Butler P, Applegate K, Birnbaum S, Brateman L, Hevezi J, Mettler F, Morin R, Pentecost M, Smith G. American College of radiology white paper on radiation dose in medicine. Journal of American College of Radiology, 2007:4:272–284.

[36] National Cancer Institute. Interventional fluoroscopy: Reducing radiation risks for patients and staff. 2005. Available at: *http://www.cancer.gov/cancertopics/interventionalfluoroscopy*.

[37] National Cancer Institute. Interventional fluoroscopy: reducing radiation risks for patients and staff. 2005 available at: *http://www.cancer.gov/cancertopics/interventionalfluoroscopy*.

that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it is NQF-endorsed (NQF # 0510). Additionally, this measure was conditionally approved by the HQA for the hospital outpatient setting in March of 2010.

Comment: Many commenters supported this measure. Commenters believed it is an important measure for monitoring radiation safety, and stated that the measure is in line with NCI recommendations.

Response: We appreciate the commenters' support.

Comment: Several commenters did not support this measure for several reasons. One commenter stated that fluoroscopy time is a relatively poor proxy for the measurement of radiation as it does not take into account the dose received. One commenter noted that the exposure to fluoroscopy time is impossible to measure since the service is bundled into the primary procedure (the time-based fluoroscopy CPT codes 76000/76001 are infrequently used), and noted that radiologists and physicians seldom document the time and codes. Commenters were concerned about the administrative and financial burdens associated with the measure. Two commenters suggested field-testing the measure and developing electronic specifications for data collection. One commenter supported the inclusion of this measure in the PQRI program only.

Response: The chart-abstracted numerator definition for this measure is currently being refined. For this reason, we are not finalizing this measure in this final rule with comment period. We appreciate the input from the commenters and will take the input into consideration in the measure refinement process.

After consideration of the public comments we received, we are not finalizing the Exposure Time Reported for Procedures Using Fluoroscopy measure at this time.

In summary, for the reasons discussed above, we have decided to not finalize at this time the 6 chart-abstracted measures we proposed to adopt for the CY 2014 payment determination. However, we still intend to propose them for inclusion in the HOP QDRP CY 2014 measure set and intend to do so in the CY 2012 OPPS/ASC proposed rule.

After consideration of the public comments we received, we are finalizing the retention of the 23 measures adopted for the CY 2013 payment determination, but are not at this time adopting any of the new measures proposed for the CY 2014 payment determination. As of now, a total of 23 measures will be used for the CY 2014 payment determination. These measures are shown below.

HOP QDRP MEASUREMENT SET TO BE USED FOR THE CY 2014 PAYMENT DETERMINATION

OP–1: Median Time to Fibrinolysis
OP–2: Fibrinolytic Therapy Received Within 30 Minutes
OP–3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP–4: Aspirin at Arrival
OP–5: Median Time to ECG
OP–6: Timing of Antibiotic Prophylaxis
OP–7: Prophylactic Antibiotic Selection for Surgical Patients
OP–8: MRI Lumbar Spine for Low Back Pain
OP–9: Mammography Follow-up Rates
OP–10: Abdomen CT—Use of Contrast Material
OP–11: Thorax CT—Use of Contrast Material
OP–12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data*
OP–13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery*
OP–14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)*
OP–15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
OP–16: Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with *Probable Cardiac Chest Pain*) Received Within 60 minutes of Arrival**
OP–17: Tracking Clinical Results between Visits**
OP–18: Median Time from ED Arrival to ED Departure for Discharged ED Patients**
OP–19: Transition Record with Specified Elements Received by Discharged Patients**
OP–20: Door to Diagnostic Evaluation by a Qualified Medical Professional**
OP–21: ED-Median Time to Pain Management for Long Bone Fracture**
OP–22: ED-Patient Left Before Being Seen**
OP–23: ED-Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival**

* New measure for the CY 2012 payment determination.
** New measure for the CY 2013 payment determination.

6. Possible Quality Measures Under Consideration for Future Inclusion in the HOP QDRP

In previous years' rulemakings, we have provided lists of quality measures that are under consideration for future adoption into the HOP QDRP measurement set. In the CY 2011 OPPS/ASC proposed rule (75 FR 46373), we set out the following list of measures under consideration for future rulemaking cycles.

MEASURES AND MEASUREMENT TOPICS UNDER CONSIDERATION FOR FUTURE PAYMENT DETERMINATIONS BEGINNING WITH CY 2013

Measures for future development:
Adjuvant Chemotherapy is Considered or Administered within 4 Months of Surgery to Patients Under Age 80 with AJCC III Colon Cancer.
Adjuvant Hormonal Therapy for Patients with Breast Cancer

MEASURES AND MEASUREMENT TOPICS UNDER CONSIDERATION FOR FUTURE PAYMENT DETERMINATIONS BEGINNING WITH CY 2013—Continued

Needle Biopsy to Establish Diagnosis of Cancer Precedes Surgical Excision/Resection.
Pneumococcal Vaccination Status
Influenza Vaccination Status
Cardiac Rehabilitation Referral
Medication Reconciliation
Appropriate surgical site hair removal
Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Heart Failure: Left Ventricular Ejection Fraction Assessment
Heart Failure: Combination Medical Therapy for Left Ventricular Systolic Dysfunction
Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction
Heart Failure: Counseling regarding Implantable Cardioverter-Defibrillator (ICD) Implantation for Patients with Left Ventricular Systolic Dysfunction on Combination Medical Therapy
Heart Failure: Patients with Left Ventricular Systolic Dysfunction on Combination Medical Therapy
Heart Failure: Symptom Management
Heart Failure: Symptom and Activity Assessment
Heart Failure: Patient Education
Heart Failure: End of Life Care Plan
Heart Failure: Overuse of Echocardiography
Heart Failure: Post-Discharge Appointment for Heart Failure Patients
Emergency Department Transfer Communication: Administrative Communications
Emergency Department Transfer Communication: Medication Information
Emergency Department Transfer Communication: Nursing Information
Emergency Department Transfer Communication: Patient Information
Emergency Department Transfer Communication: Physician Information
Emergency Department Transfer Communication: Procedures and Tests
Emergency Department Transfer Communication: Vital Signs
Measurement Topics for future development:
Chemotherapy
Unplanned Reintubation
Unplanned Inpatient Transfer
Post-discharge follow up
Post-discharge ED visit within 72 hours
Safe Surgery Checklist
Immunization Refusal rate
Breast cancer detection rate

We invited public comment on these quality measures and topics so that we may consider proposing to adopt them beginning with the CY 2013 payment determination. We also sought suggestions and rationales to support the adoption of measures and topics for the HOP QDRP which do not appear in the table above.

We received general comments on the measure topics under consideration or targeted for future development.

Comment: One commenter urged CMS to not adopt measures for the HOP QDRP that are duplicative of measures adopted for the Hospital Inpatient Quality Reporting Program. One commenter opposed the adoption of any of these future measures because they will impose an additional burden on HOPDs that will increase patient wait times and decrease their satisfaction.

Response: As we have previously stated, our goal is to align the HOP QDRP and the Hospital Inpatient Quality Reporting Program measures to reduce the burden for hospitals. Nonetheless, there are instances when the inclusion of the same measures is appropriate for both settings because the measures assess important aspects of care that are furnished in both settings, and because adopting them for both settings allows us to make comparisons across care settings. Although we understand the commenter's concerns regarding the increased burden that may accompany the adoption of additional quality measures for the HOP QDRP, we believe that expanding the scope of the HOP QDRP is an important tool that will heighten hospitals' awareness of the quality of care they provide and highlight opportunities for quality improvement.

Comment: One commenter encouraged CMS to require mammogram providers to track individual rates or use the ACR national mammography database registry.

Response: We thank the commenter for the input and will take it into consideration as we engage in future measure development.

Comment: One commenter requested that CMS avoid using vague language and instead provide more details on proposed measures. One commenter requested that CMS focus on issues that are identified as national concerns and are supported by evidence-based practice guidelines. Another commenter recommended that CMS adopt more claim-based measures and less chart-abstracted measures. The commenter also suggested that CMS minimize the number of measures it adopts on certain topics, such as documentation-based universal protocol measures like the "Safety Surgery Checklist" measure, which the commenter believed has little correlation to patient outcomes, and the heart failure measures listed in the table of measures under consideration for the future, which the commenter believed have no impact on reducing readmission rates.

Response: We thank the commenters for the suggestions and will take them into consideration as we consider what measures to adopt for the HOP QDRP.

Comment: We also received recommendations for new measure topics for the HOP QDRP:

- Healthcare Associated Infections
- Interactions between hospital EDs and ambulances
- Day-to-day treatment of cancer patients (adopt the Quality Oncology Practice Initiative measure)
- EHR-based measure to track to send reminders to patients with chronic

conditions about using preventive services

- Vital signs frequency
- Medication errors
- Diagnostic Mammography Positive Predictive Value 2 (PPV2—Biopsy recommended)
- Screening Mammography Positive Predictive Value 2 (PPV2—Biopsy Recommended)
- Cancer Detection Rate
- Abnormal Interpretation Rate (Recall Rate)
- Patient Experience survey (reporting the data as a Heart Failure Quality of Care composite)
- ED AMI Mortality measure and ED Non-Mortality Outcome measures
- Appropriate use of Vancomycin to reduce MRSA
- Appropriate nursing staffing ratios
- Patient seen in the ED with a STEMI who did not receive a fibrinolytic or PCI or transfer for further coronary care
- Care transition
- PET Myocardial Perfusion Imaging

Response: We thank the commenters for their input regarding future quality measures for the HOP QDRP.

We also received comments on individual measure topics under consideration or targeted for future development.

- Needle Biopsy To Establish Diagnosis of Cancer Precedes Surgical Excision/Resection

Comment: One commenter supported this measure because it is a standard practice.

Response: We thank the commenter for the support and will take the comment into consideration as we consider additional measures to adopt for the HOP QDRP.

- Pneumococcal Vaccination Status

Comment: Two commenters supported this measure and one commenter did not support this measure.

Response: We thank the commenters for their input and will take the comments into consideration as we consider additional measures to adopt for the HOP QDRP.

- Influenza Vaccination Status

Comment: One commenter supported the measure and one commenter did not support this measure.

Response: We thank the commenters for their input and will take the comments into consideration as we consider additional measures to adopt for the HOP QDRP.

- Cardiac Rehabilitation Referral

Comment: One commenter supported this measure. One commenter recommended that CMS adopt the NQF-endorsed Cardiac Rehabilitation Referral performance measure as published by the ACC and the American Heart Association as a quality indicator in the acute myocardial infarction measure set.

Response: We thank the commenters for their input and will take the comments into consideration as we consider additional measures to adopt for the HOP QDRP.

- Medication Reconciliation

Comment: One commenter supported this measure.

Response: We thank the commenter for supporting the measure and will take the comment into consideration as we consider additional measures to adopt for the HOP QDRP.

- Appropriate Surgical Site Hair Removal

Comment: Two commenters did not support this measure because they believed that it is not meaningful for consumers and purchasers.

Response: We thank the commenters for their input and we will take the comments into consideration as we consider additional measures to adopt for the HOP QDRP.

- Heart Failure Measures

Comment: Two commenters supported the Heart Failure measures. One commenter supported the use of a registry while another commenter was concerned about the potential cost burden due to the potential requirement for registry participation. Commenters also recommended harmonizing 7 of the 14 heart failure measures that are duplicative of the Hospital Inpatient Quality Reporting Program measures.

Response: We thank the commenters for their input and will take the comments into consideration as we consider additional measures to adopt for the HOP QDRP.

- Heart Failure: Patient Education

Comment: One commenter supported this measure.

Response: We thank the commenter for the support and will take the comments into consideration as we consider additional measures to adopt for the HOP QDRP.

- Heart Failure: End of Life Care Plan

Comment: One commenter supported this measure.

Response: We thank the commenter for the support and will take the comments into consideration as we consider additional measures to adopt for the HOP QDRP.

- Heart Failure: Overuse of Echocardiography

Comment: One commenter supported this measure.

Response: We thank the commenter for the support and will take it into consideration as we consider additional measures to adopt for the HOP QDRP.

- Heart Failure: Post-Discharge Appointment for Heart Failure Patients

Comment: One commenter supported this measure.

Response: We thank the commenter for the support and will take it into consideration as we consider additional measures to adopt for the HOP QDRP.

- Emergency Department Transfer Communication

Comment: Many commenters supported this NQF-endorsed measure. Commenters believed this measure is relevant for measuring the performance of CAHs and rural hospitals which handle a large volume of patient transfers. Commenters stated that the measure will facilitate the standardized transfer of information provided by EDs, rural, and critical access hospitals. Commenters also encouraged CMS to consider adopting more quality measures for rural facilities. Some commenters raised concerns about medical staff documentation and patient communication issues associated with this measure. One commenter cautioned that CMS needs to ensure that the measure is in conformity with current EMTALA regulations and guidelines.

Response: We thank the commenters for their input and will take the comments into consideration as we consider additional measures to adopt for the HOP QDRP.

- Unplanned Reintubation

Comment: One commenter did not believe the measure is linked to quality of care and stated that there is no evidence-based standard of practice.

Response: We thank the commenter for the input and will take it into consideration as we consider additional measures to adopt for the HOP QDRP.

- Post-Discharge Emergency Visits Within 72 Hours

Comment: One commenter suggested that CMS consider whether an ED patient previously received care at another hospital ED when attributing responsibility for performance on a measure like this to an individual hospital.

Response: We thank the commenter for the input and will take it into

consideration as we consider additional measures to adopt for the HOP QDRP.

- Immunization Refusal Rate Measure

Comment: One commenter did not support the measure based on the notion that a patient's right to refuse immunization should not be construed as a reflection of hospital quality. The commenter requested that CMS provide evidence that supports the correlation between the immunization refusal rate and the quality of care furnished by an HOP QDRP.

Response: We thank the commenter for the input and will take it into consideration as we consider additional measures to adopt for the HOP QDRP.

- Breast Cancer Detection Rate

Comment: One commenter was pleased with this measure, but was concerned about how the measure would be specified, collected and reported. The commenter recommended that at a minimum, the Breast Cancer Detection Rate measure should be calculated in concert with the Mammography Follow-Up Rate measure.

Response: This measure is currently under development, and this input will be taken under consideration.

In addition, we expressed concern about the lack of progress in reducing the rates of healthcare associated infections (HAIs) that was recently reported in the 2009 National Healthcare Quality Report (*http://www.ahrq.gov/qual/nhqr09/nhqr09.pdf*). For example, the report found that rates of postoperative sepsis increased by 8 percent. We view healthcare associated infections as a significant priority for quality measurement in order to ensure that health care does not result in avoidable harm and to inform the public about hospitals' performance with respect to these infections. We invited public comment on the option to include among our prioritization criteria quality measures that assess performance on healthcare associated infections. Also, while some HOP QDRP measures cover aspects of healthcare associated infections, we invited suggestions on additional measures that could be added to those that hospitals would report and that we would make available to the public in order to promote improvement in healthcare associated infection rates.

Comment: A few commenters were very pleased with CMS' concerns regarding the issue of HAIs and believed they should be ranked high priority. Commenters encouraged CMS to continue to explore whether it would be feasible to adopt more HAIs in the HOP QDRP and hospital-value-based purchasing program (HVBP), specifically the "never events." A few commenters expressed support for evidence-based HAI measures.

Response: We appreciate the commenters' strong support and encouragement. We will look for opportunities to include such measures in our quality reporting and pay for performance programs in the future.

Comment: Many commenters made suggestions with respect to the HAI selection criteria CMS should use in the HOP QDRP. Some commenters recommended using the metrics/targets that will be specified in the National Strategy for Quality Improvement that the Secretary establishes under the Affordable Care Act as guidance to develop new HAI measures. Some commenters favored the HHS HAI Action Plan. One commenter believed the HAI quality measures that are currently reported to the CDC's National Healthcare Safety Network (NHSN) will provide more robust data (compared to administrative data) for HAI tracking and assessment. The commenter stated that the adoption of CDC–NHSN measures will increase harmonization of State and Federal HAI reporting requirements while minimizing the additional reporting effort required of hospitals. One commenter suggested developing HAIs based on sentinel events reported to the Joint Commission, and using the Joint Commission—Hospital Accreditation Program: Infection Preventions Standards as a guide. One commenter recommended the adoption of the guidelines developed by the Association for Professionals in Infection Control & Epidemiology.

Response: We thank the commenters for making suggestions regarding t HAI measure selection criteria and guidelines. The HHS HAI Action Plan to reduce Healthcare Associated Infections is a Department-wide action plan to reduce healthcare associated infections. It was released in 2009 and is currently undergoing revision. It contains a set of seven metrics selected by HHS that are meant to be used for nationwide quality improvement, and also contains national improvement goals for these metrics. We contribute to the HHS Action Plan to reduce Healthcare Associated Infections, and we also are collaborating closely with the CDC to incorporate the NHSN measures for infection rate reporting into our hospital quality reporting and pay for performance programs. Measures of process of care for sepsis will be considered in the future.

Comment: Many commenters indicated their preferences with respect to the types of HAI measures that should be included in the HOP QDRP. One commenter recommended Surgical Care Improvement Project (SCIP) Infection, and the Surgical Site Infection measures (NQF #0299) that NHSN reports. Specifically, the commenter recommended the inclusion of this measure in conjunction with the "Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into Their Qualified/Certified EHR System as Discrete Searchable Data" measure (NQF #0489). The commenter strongly believed the two measures would make a difference between life and death for patients with sepsis, deep wound or surgical site infections. With rapid diagnosis and timely receipt of lab results, healthcare providers are able to treat patients while they are being seen rather than necessitating a return visit or follow-up phone call. For HAI measure topics, one commenter recommended MRSA colonization prior to invasive surgery or at admission to an acute care facility, hand-hygiene adherence, and use of barrier precautions. One commenter opposed the inclusion of the catheter-associated urinary tract infections (UTIs) HAI because the commenter believed that UTIs are not fully preventable and stated that they are hard to diagnose at the time of admission without urine screening and cultures. Furthermore, the commenter was concerned with the high cost for screening all patients undergoing surgery in HOPDs and added that the practice is inconsistent with the "Diagnosis, Prevention and Treatment of Catheter-Associated Urinary Tract Infection in Adults: 2009 International Clinical Practice Guidelines from the Infectious Diseases Society of America", which recommended that catheter-associated asymptomatic bacteriuria should not be screened.

Response: We thank the commenters for their suggestions for HAI measure topics. We disagree with the statement that UTIs are not preventable. In fact, the majority of CAUTIs are preventable by avoiding unnecessary catheterization, and by limiting the duration of catheterization. In our view, it is unnecessary to screen all patients on arrival because the vast majority of patients do not have a urinary tract infection at arrival. Catheters are used too commonly, often without appropriate justification. Very often, many catheters are left in far too long and most hospitals do not have good systems to identify patients that need to

have the catheter removed. We are working with CDC to develop metrics of infection control and outcomes.

Comment: One commenter was very concerned about the outdated infection control data used by CMS to make policy decisions.

Response: We agree that there is a need for more current data on the actual rates of healthcare-associated infections and we are working closely with the CDC to obtain this information and performance metrics.

We thank the commenters for their input regarding the adoption of HAI quality measures in the HOP QDRP measure set.

C. Payment Reduction for Hospitals That Fail To Meet the HOP QDRP Requirements for the CY 2011 Payment Update

1. Background

Section 1833(t)(17)(A) of the Act, which applies to subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Act), requires that hospitals that fail to report data required for the quality measures selected by the Secretary, in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act, incur a 2.0 percentage point reduction to their OPD fee schedule increase factor, that is, the annual payment update factor. Section 1833(t)(17)(A)(ii) of the Act specifies that any reduction would apply only to the payment year involved and would not be taken into account in computing the applicable OPD fee schedule increase factor for a subsequent payment year.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68769 through 68772), we discussed how the payment reduction for failure to meet the administrative, data collection, and data submission requirements of the HOP QDRP affected the CY 2009 payment update applicable to OPPS payments for HOPD services furnished by the hospitals defined under section 1886(d)(1)(B) of the Act to which the program applies. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that apply to certain outpatient items and services provided by hospitals that are required to report outpatient quality data and that fail to meet the HOP QDRP requirements. All other hospitals paid under the OPPS receive the full OPPS payment update without the reduction.

The national unadjusted payment rates for many services paid under the OPPS equal the product of the OPPS conversion factor and the scaled relative weight for the APC to which the service is assigned. The OPPS conversion factor, which is updated annually by the OPD fee schedule increase factor, is used to calculate the OPPS payment rate for services with the following status indicators (listed in Addendum B to this final rule with comment period): "P," "Q1," "Q2," "Q3," "R," "S," "T," "V," "U," or "X." In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68770), we adopted a policy that payment for all services assigned these status indicators would be subject to the reduction of the national unadjusted payment rates for applicable hospitals, with the exception of services assigned to New Technology APCs with assigned status indicator "S" or "T," and brachytherapy sources with assigned status indicator "U," which were paid at charges adjusted to cost in CY 2009. We excluded services assigned to New Technology APCs from the list of services subject to the reduced national unadjusted payment rates because the OPD fee schedule increase factor is not used to update the payment rates for these APCs.

In addition, section 1833(t)(16)(C) of the Act, as amended by section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275), specifically required that brachytherapy sources be paid during CY 2009 on the basis of charges adjusted to cost, rather than under the standard OPPS methodology. Therefore, the reduced conversion factor also was not applicable to CY 2009 payment for brachytherapy sources because payment would not be based on the OPPS conversion factor and, consequently, the payment rates for these services were not updated by the OPD fee schedule increase factor. However, in accordance with section 1833(t)(16)(C) of the Act, as amended by section 142 of the MIPPA, payment for brachytherapy sources at charges adjusted to cost expired on January 1, 2010. Therefore, in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60641), we finalized our CY 2010 proposal, without modification, to apply the reduction to payment for brachytherapy sources to hospitals that fail to meet the quality data reporting requirements of the HOP QDRP for the CY 2010 OPD fee schedule increase factor.

The OPD fee schedule increase factor, or market basket update, is an input into the OPPS conversion factor, which is used to calculate OPPS payment rates. To implement the requirement to reduce the market basket update for hospitals that fail to meet reporting requirements, we calculate two conversion factors: A full market basket conversion factor (that is, the full conversion factor), and a reduced market basket conversion factor (that is, the reduced conversion factor). We then calculate a reduction ratio by dividing the reduced conversion factor by the full conversion factor. We refer to this reduction ratio as the "reporting ratio" to indicate that it applies to payment for hospitals that fail to meet their reporting requirements. Applying this reporting ratio to the OPPS payment amounts results in reduced national unadjusted payment rates that are mathematically equivalent to the reduced national unadjusted payment rates that would result if we multiplied the scaled OPPS relative weights by the reduced conversion factor. To determine the reduced national unadjusted payment rates that applied to hospitals that failed to meet their quality reporting requirements for the CY 2010 OPPS, we multiply the final full national unadjusted payment rate in Addendum B to the CY 2010 OPPS/ASC final rule with comment period by the CY 2010 OPPS final reporting ratio of 0.980 (74 FR 60642).

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68771 through 68772), we established a policy that the Medicare beneficiary's minimum unadjusted copayment and national unadjusted copayment for a service to which a reduced national unadjusted payment rate applies would each equal the product of the reporting ratio and the national unadjusted copayment or the minimum unadjusted copayment, as applicable, for the service. Under this policy, we apply the reporting ratio to both the minimum unadjusted copayment and national unadjusted copayment for those hospitals that receive the payment reduction for failure to meet the HOP QDRP reporting requirements. This application of the reporting ratio to the national unadjusted and minimum unadjusted copayments is calculated according to § 419.41 of our regulations, prior to any adjustment for hospitals' failure to meet the quality reporting standards according to § 419.43(h). Beneficiaries and secondary payers thereby share in the reduction of payments to these hospitals.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68772), we established the policy that all other applicable adjustments to the OPPS national unadjusted payment rates apply in those cases when the OPD fee schedule increase factor is reduced for hospitals that fail to meet the requirements of the HOP QDRP. For example, the following standard adjustments apply to the reduced national unadjusted payment rates: The

wage index adjustment; the multiple procedure adjustment; the interrupted procedure adjustment; the rural sole community hospital adjustment; and the adjustment for devices furnished with full or partial credit or without cost. We believe that these adjustments continue to be equally applicable to payments for hospitals that do not meet the HOP QDRP requirements. Similarly, outlier payments will continue to be made when the criteria are met. For hospitals that fail to meet the quality data reporting requirements, the hospitals' costs are compared to the reduced payments for purposes of outlier eligibility and payment calculation. This policy conforms to current practice under the IPPS. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60642), we continued this policy. For a complete discussion of the OPPS outlier calculation and eligibility criteria, we refer readers to section II.G. of this CY 2011 OPPS/ASC final rule with comment period.

2. Reporting Ratio Application and Associated Adjustment Policy for CY 2011

In the CY 2011 OPPS/ASC proposed rule (75 FR 46376), we proposed to continue our established policy of applying the reduction of the OPD fee schedule increase factor through the use of a reporting ratio for those hospitals that fail to meet the HOP QDRP requirements for the full CY 2011 annual payment update factor. For the CY 2011 OPPS, the proposed reporting ratio was 0.980, calculated by dividing the reduced conversion factor of $66.930 by the full conversion factor of $68.267. The final CY 2011 OPPS reporting ratio is 0.980, calculated by dividing the reduced conversion factor of $67.530 by the full conversion factor of $68.876. We proposed to continue to apply the reporting ratio to all services calculated using the OPPS conversion factor. For the CY 2011 OPPS, we proposed to apply the reporting ratio, when applicable, to all HCPCS codes to which we have assigned status indicators "P," "Q1," "Q2," "Q3," "R," "S," "T," "V," "U," and "X" (other than new technology APCs to which we have assigned status indicators "S" and "T"). We proposed to continue to exclude services paid under New Technology APCs. We proposed to continue to apply the reporting ratio to the national unadjusted payment rates and the minimum unadjusted and national unadjusted copayment rates of all applicable services for those hospitals that fail to meet the HOP QDRP reporting requirements. We also proposed to continue to apply all other applicable standard adjustments to the OPPS national unadjusted payment rates for hospitals that fail to meet the requirements of the HOP QDRP. Similarly, we proposed to continue to calculate OPPS outlier eligibility and outlier payment based on the reduced payment rates for those hospitals that fail to meet the reporting requirements.

We did not receive any public comments on our CY 2011 proposal to apply the HOP QDRP reduction in the manner described in the paragraph above and, therefore, are finalizing our proposal, without modification. For the CY 2011 OPPS, we are applying a reporting ratio of 0.980 to the national unadjusted payments, minimum unadjusted copayments, and national unadjusted copayments for all applicable services for those hospitals failing to meet the HOP QDRP reporting requirements. This reporting ratio applies to HCPCS codes assigned status indicators "P," "Q1," "Q2," "Q3," "R," "S," "T," "U," "V," or "X," excluding services paid under New Technology APCs. All other applicable standard adjustments to the OPPS national unadjusted payment rates for hospitals that fail to meet the requirements of the HOP QDRP will continue to apply. We continue to calculate OPPS outlier eligibility and outlier payment based on the reduced rates for those hospitals that fail to meet the reporting requirements.

D. Requirements for HOPD Quality Data Reporting for CY 2012 and Subsequent Years

In order to participate in the HOP QDRP, hospitals must meet administrative, data collection and submission, and data validation requirements (if applicable). Hospitals that do not meet the requirements of the HOP QDRP, as well as hospitals not participating in the program and hospitals that withdraw from the program, will not receive the full OPPS payment rate update. Instead, in accordance with section 1833(t)(17)(A) of the Act, those hospitals will receive a reduction of 2.0 percentage points in their annual payment update factor for the applicable payment year. We established the payment determination requirements for the CY 2011 payment update in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60642 through 60652).

In the CY 2011 OPPS/ASC proposed rule (75 FR 46376 through 46381), for payment determinations affecting the CY 2012 payment update, we proposed to implement the requirements listed below. Most of these requirements are the same as the requirements we implemented for the CY 2011 payment determination, with some proposed modifications.

1. Administrative Requirements

To participate in the HOP QDRP, we proposed that several administrative steps be completed. These steps would require the hospital to:

- Identify a QualityNet security administrator who follows the registration process located on the QualityNet Web site (*http://www.QualityNet.org*) and submits the information to the appropriate CMS-designated contractor. All CMS-designated contractors would be identified on the QualityNet Web site. The same person may be the QualityNet security administrator for both the Hospital Inpatient Quality Reporting Program and the HOP QDRP. From our experience, we believe that the QualityNet security administrator typically fulfills a variety of tasks related to the hospital's ability to participate in the HOP QDRP, such as: Creating, approving, editing and/or terminating QualityNet user accounts within the organization; monitoring QualityNet usage to maintain proper security and confidentiality measures; and serving as a point of contact for information regarding QualityNet and the HOP QDRP. The hospital would be required to maintain a current QualityNet security administrator for as long as the hospital participates in the program due to CMS information systems security requirements. While only a single QualityNet security administrator would be required for program purposes, we suggest to hospitals that it may be beneficial to have more than one QualityNet security administrator for back-up purposes.
- Register with QualityNet, regardless of the method used for data submission.
- Complete and submit an online participation form if this form (or a paper Notice of Participation form) has not been previously completed, if a hospital has previously withdrawn, or if the hospital acquires a new CCN. For HOP QDRP decisions affecting the CY 2012 payment determination, hospitals that share the same CCN would be required to complete a single online participation form. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68772), we implemented an online registration form and eliminated the paper form. At this time, the participation form for the HOP QDRP is separate from the Hospital Inpatient Quality Reporting Program and completing a form for each program is required. Agreeing to participate includes acknowledging that the data submitted to the CMS-designated

contractor would be submitted to CMS, shared with one or more other CMS contractors that support the implementation of the HOP QDRP and be publicly reported.

We proposed to update and retain the following deadlines, which we established in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60643), for submitting the participation form:

Hospitals with Medicare acceptance dates on or after January 1, 2011: For the CY 2012 payment update, we proposed that any hospital that has a Medicare acceptance date on or after January 1, 2011 (including a new hospital and hospitals that have merged) must submit a completed participation form no later than 180 days from the date identified as its Medicare acceptance date on the CMS Online System Certification and Reporting (OSCAR) system. Hospitals typically receive a package notifying them of their new CCN after they receive their Medicare acceptance date. The Medicare acceptance date is the earliest date that a hospital can receive Medicare payment for the services that it furnishes. Completing the participation form would include supplying the name and address of each hospital campus that shares the same CCN.

The use of the Medicare acceptance date as beginning the timeline for HOP QDRP participation allows CMS to monitor more effectively hospital compliance with the requirement to complete a participation form because a hospital's Medicare acceptance date is readily available to CMS through its data systems. In addition, providing an extended time period to register for the program would allow newly functioning hospitals sufficient time to get their operations fully functional before having to collect and submit quality data. We invited public comment on this proposed policy.

Hospitals with Medicare acceptance dates before January 1, 2011: For the CY 2012 payment update, we proposed that any hospital that has a Medicare acceptance date on or before December 31, 2010 that is not currently participating in the HOP QDRP and wishes to participate in the CY 2012 HOP QDRP must submit a participation form by March 31, 2011. We proposed a deadline of March 31, 2011, because we believe it would give hospitals sufficient time to decide whether they wish to participate in the HOP QDRP, as well as put into place the necessary staff and resources to timely report data for first quarter CY 2011 services. This requirement would apply to all hospitals whether or not the hospital billed for payment under the OPPS.

Under our current requirements, hospitals that want to withdraw from participation must follow the same deadlines as hospitals that want to participate. We proposed to change this requirement. We proposed to lengthen the time during which hospitals may withdraw from participation because we believe that hospitals should be allowed more time to consider this decision. In addition, this increased time to withdraw is comparable programmatically to our approach under the Hospital Inpatient Quality Reporting Program (75 FR 23996 and 50231). Specifically, for the CY 2012 payment update, we proposed that any HOP QDRP participating hospital that wants to withdraw may do so at any time from January 1, 2011 to November 1, 2011. Hospitals that withdraw during this time period for the CY 2012 payment update would not be able to sign up to participate for the CY 2012 payment update, would have a 2.0 percentage point reduction in their CY 2012 payment update, and would be required to resubmit a participation form in order to participate for purposes of any future payment updates. We note that once a hospital has submitted a participation form, it is considered to be an active HOP QDRP participant until such time as the hospital submits a withdrawal form to CMS or the facility is designated as closed in the CMS OSCAR system. We invited public comment on this proposed policy.

We did not receive any public comments on our CY 2011 proposals for HOP QDRP administrative requirements for the CY 2012 payment determination; therefore, we are finalizing our proposals without modification.

2. Data Collection and Submission Requirements

a. General Data Collection and Submission Requirements

In the CY 2011 OPPS/ASC proposed rule (75 FR 46377 through 46379), we proposed that, to be eligible for the full CY 2012 OPPS payment update, hospitals would be required to:

- Submit data: Hospitals that would be participating in the HOP QDRP would be required to submit data for each applicable quarter by the deadline posted on the QualityNet Web site; there must be no lapse in data submission. For the CY 2012 annual payment update, the applicable quarters would be as follows: 3rd quarter CY 2010, 4th quarter CY 2010, 1st quarter CY 2011, and 2nd quarter CY 2011. Hospitals that did not participate in the CY 2011 HOP QDRP, but would like to participate in the CY 2012 HOP QDRP, and that have a Medicare acceptance date on the OSCAR system before January 1, 2011, would begin data submission for 1st quarter CY 2011 services using the CY 2012 measure set that would be finalized in the CY 2011 OPPS/ASC final rule with comment period. For those hospitals with Medicare acceptance dates on or after January 1, 2011, data submission must begin with the first full quarter following the submission of a completed online participation form. For the claims-based measures, we would calculate the measures using the hospital's Medicare claims data. For the CY 2012 payment update, we would utilize paid Medicare FFS claims submitted prior to January 1, 2011, to calculate these measures. For the structural measure to be used for the CY 2012 payment determination, hospitals would be required to submit data beginning with January 1, 2011 discharges using a Web-based tool available on QualityNet beginning in 2011.

Sampling and Case Thresholds: It would not be necessary for a hospital to submit data for all eligible cases for some measures if sufficient eligible case thresholds are met. Instead, for those measures where a hospital has a sufficiently large number of cases, the hospital would sample cases and submit data for these sampled cases rather than submitting data from all eligible cases. This sampling scheme, which includes the minimum number of cases based upon case volume, would be set out in the HOPD Specifications Manual at least 3 months in advance of the required data collection. We proposed to change this notification timeframe for this sampling scheme to at least 3 months from at least 4 months to be consistent with the HOPD Specifications Manual release schedule. Hospitals would be required to meet the sampling requirements for required quality measures each reporting quarter.

In addition, in order to reduce the burden on hospitals that treat a low number of patients but otherwise meet the submission requirements for a particular quality measure, hospitals that have five or fewer claims (both Medicare and non-Medicare) for any measure included in a measure topic in a quarter would not be required to submit patient level data for the entire measure topic for that quarter. Even if hospitals would not be required to submit patient level data because they have five or fewer claims (both Medicare and non-Medicare) for any measure included in a measure topic in

a quarter, we proposed that they may voluntarily do so.

Hospitals would be required to submit all required data according to the data submission schedule that will be available on the QualityNet Web site (*https://www.QualityNet.org*). This Web site meets or exceeds all current HIPAA requirements. Submission deadlines would, in general, be 4 months after the last day of each calendar quarter. Thus, for example, the submission deadline for data for services furnished during the first quarter of CY 2011 (January–March 2011) would be on or around August 1, 2011. The actual submission deadlines would be posted on the *http://www.QualityNet.org* Web site.

Hospitals would be required to submit data to the OPPS Clinical Warehouse using either the CMS Abstraction and Reporting Tool for Outpatient Department (CART–OPD) measures or the tool of a third-party vendor that meets the measure specification requirements for data transmission to QualityNet.

Hospitals would be required to submit quality data through My QualityNet, the secure portion of the QualityNet Web site, to the OPPS Clinical Warehouse. The OPPS Clinical Warehouse, which is maintained by a CMS-designated contractor, would submit the OPPS Clinical Warehouse data to CMS. OPPS Clinical Warehouse data are not currently considered to be Quality Improvement Organization (QIO) data; rather, we consider such data to be CMS data. However, it is possible that the information in the OPPS Clinical Warehouse may at some point become QIO information. If this occurs, these data would also become protected under the stringent QIO confidentiality regulations in 42 CFR part 480.

Hospitals would be required to collect HOP QDRP data from outpatient episodes of care to which the required measures apply. For the purposes of the HOP QDRP, an outpatient "episode of care" is defined as care provided to a patient who has not been admitted as an inpatient, but who is registered on the hospital's medical records as an outpatient and receives services (rather than supplies alone) directly from the hospital. Every effort would be made to ensure that data elements common to both inpatient and outpatient settings are defined consistently for purposes of quality reporting (such as "time of arrival").

Hospitals would be required to submit quality data using the CCN under which the care was furnished.

To be accepted into the OPPS Clinical Warehouse, data submissions, at a minimum, would be required to be timely, complete, and accurate. Data submissions are considered to be "timely" when data are successfully accepted into the OPPS Clinical Warehouse on or before the reporting deadline. A "complete" submission would be determined based on whether the data satisfy the sampling criteria that are published and maintained in the HOPD Specifications Manual, and must correspond to both the aggregate number of cases submitted by a hospital and the number of Medicare claims the hospital submits for payment. We are aware of "data lags" that occur when hospitals submit claims, then cancel and correct those claims; efforts would be made to take such events into account that can change the aggregate Medicare case counts. To be considered "accurate," submissions would be required to pass validation, if applicable.

We strongly recommend that hospitals review OPPS Clinical Warehouse feedback reports and the HOP QDRP Provider Participation Reports that are accessible through their QualityNet accounts. These reports enable hospitals to verify whether the data they or their vendors submitted were accepted into the OPPS Clinical Warehouse and the date/time that such acceptance occurred. We also note that irrespective of whether a hospital submits data to the OPPS Clinical Warehouse itself or uses a vendor to complete the submissions, the hospital would be responsible for ensuring that HOP QDRP requirements are met.

Finally, during the past two years of the HOP QDRP, the submission of population and sampling data was not required, though hospitals could submit, on a voluntary basis, the aggregate numbers of outpatient episodes of care which are eligible for submission under the HOP QDRP and sample size counts. These aggregated numbers of outpatient episodes represent the number of outpatient episodes of care in the universe of all possible cases eligible for data reporting under the HOP QDRP. For the CY 2012 payment update, we proposed to require submission of this population and sample size data. Specifically, we proposed that hospitals must submit on a quarterly basis, aggregate population and sample size counts for Medicare and non-Medicare encounters for the measure populations for which chart-abstracted data must be submitted. Under this proposal, hospitals would submit aggregate population and sample size counts for measure populations even if the hospital had not treated patients in a specific measure population; that is, if a hospital has not treated any patients in a specific HOP QDRP measure population, the hospital would still be required to submit a zero for its quarterly aggregate population and sample counts to meet the requirement.

We believe that hospitals have had sufficient time to become familiar with HOP QDRP data and to develop data systems necessary to support this requirement. We view it as vital for quality data reporting for hospitals to be able to determine accurately their aggregate population and appropriate sampling size data to assess their completeness of data reporting. We rely on hospitals to properly sample cases where sampling occurs so that representative data are submitted; for hospitals to correctly sample, it is necessary for them to be able to determine their aggregate population sizes. In addition, we believe it is beneficial for hospitals to develop systems that can determine whether or not they have furnished services or billed for five or fewer cases for a particular measure topic on a quarterly basis.

We proposed that the deadlines for the reporting of aggregate numbers of outpatient episodes of care and sample size counts would be the same as those for the reporting of data for the measures requiring chart abstraction, and these deadlines would be posted on the data submission schedule that would be available on the QualityNet Web site. Hospitals would be permitted to submit this information prior to the deadline; this would allow CMS to advise hospitals regarding their incomplete submission status as appropriate and give hospitals sufficient time to make appropriate revisions before the data submission deadline.

We plan to use the aggregate population and sample size data to assess data submission completeness and adherence to sampling requirements for Medicare and non-Medicare patients.

We invited public comment on these proposed requirements. The public comments we received and our responses are outlined below.

Comment: One commenter supported the requirement that hospital outpatient departments report quality data under the HOP QDRP. This commenter stated a belief that payment incentives to increase the reporting of data by hospital outpatient departments represent a useful tool in promoting transparency.

Response: We thank the commenter for supporting hospital outpatient quality data reporting under the HOP QDRP, the use of the 2.0 percentage

point reduction for hospitals that do not successfully report quality data, and the use of payment incentives to promote transparency.

Comment: One commenter stated that frontline workers are important in data collection and reporting for the HOP QDRP and that the best interests of patients would be served if frontline healthcare workers are guaranteed a voice in the development and implementation of mechanisms to collect quality data.

Response: We agree with the commenter that those that perform the work for data collection and reporting for the HOP QDRP should have a voice in the development and implementation of mechanisms to collect quality data. To that end, we encourage these workers as well as other members of the public to participate in the comment process for the OPPS/ASC proposed rule with comment period. In addition, CMS offers educational programs, including programs that include discussions of proposed and final HOP QDRP requirements and encourages the public to submit input directly to the HOP QDRP support contractor or via a question and answer tool located at *https://cms-ocsq.custhelp.com/cgi-bin/cms_ocsq.cfg/php/enduser/home.php?p_sid=_*crJryj&p_accessibility=0&p_redirect=*.

Comment: One commenter asked for the definition of an outpatient and whether this definition would include patients obtaining testing only or must patients be in an outpatient bed.

Response: The term "outpatient" is defined in the Medicare Claims Processing Manual, Chapter 1, Section 50.3.1. This section states that "outpatient" means a person who has not been admitted as an inpatient but who is registered on the hospital or critical access hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH." Therefore, "outpatients" could include patients solely obtaining diagnostic services, as well as those patients who have been placed in a bed, provided they meet the applicable definition of "outpatient."

Comment: Some commenters agreed that hospitals with five or fewer claims for a specific measure should not be required to submit patient-level data for the entire measure topic for that quarter, but should be allowed to submit data voluntarily. These commenters stated their belief that this exception should apply to hospitals with less than six Medicare claims, not less than six claims across all payers.

Response: We thank the commenters for supporting our policy to not require hospitals with five or fewer claims for a specific measure for a quarter to submit data while allowing these hospitals to report data voluntarily. With respect to the commenters' suggestion that we modify our policy to apply to five or fewer Medicare claims (rather than five or fewer Medicare and non-Medicare claims), we selected more than 5 cases per quarter (more than 20 cases per year) as the minimum threshold to ensure that the vast majority of hospitals with sufficient caseload would be required to submit data, while easing the burden on hospitals whose patient counts were too small to reliably report hospital measure results. Because we collect data on both Medicare and non-Medicare patients, we believe it is appropriate to set our case thresholds using the population for which we are collecting data, which includes both Medicare and non-Medicare patients.

Comment: One commenter stated that the term "encounter" is not defined in the outpatient setting, and it is not so clear cut. This commenter questioned for what purpose does the CMS need population and sampling data as the proposed rule was not clear about the ultimate purpose for these data collections.

Response: We disagree with the commenter that the term "encounter" is not defined in the outpatient setting. We refer the commenter to the definition of hospital outpatient "encounter" in the CMS Medicare Benefit Policy Manual, Chapter 6, Section 20.3, which states the following: "A hospital outpatient 'encounter' is a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient." Regarding the ultimate purpose of reported population and sampling data, as we have stated previously, (74 FR 60645), and in this proposed rule with comment period, we plan to use the aggregate population and sample size data to assess data submission completeness and adherence to sampling requirements for Medicare and non-Medicare patients. Further, as we stated in our proposal, we view it as vital for quality data reporting that hospitals be able to determine accurately their aggregate population and appropriate sampling size data to assess their completeness of data reporting.

Comment: Many commenters stated their belief that collecting population and sampling data for outpatient measures is burdensome and time-consuming for hospitals. These commenters urged CMS to not finalize this provision to collect such data as the challenges to do so are particularly great for both larger hospitals and smaller hospitals. Some of these commenters cited specific underlying factors for hospitals of certain size; that larger hospitals have very large patient populations and smaller hospitals have less integrated HIT systems. Some commenters expressed concern that identifying outpatient populations is difficult and that it may not be possible for an all-payer patient population because outpatient billing is more varied and less defined than inpatient billing. One commenter stated that unlike inpatient information which is located in a single facility, outpatient population and sample size data may be located in diverse outpatient settings and a hospital's ability to manage this data from diverse sources could be problematic because of the time, cost, and resource commitment for this requirement. One commenter stated that in some cases hospital charges are written off or not billed in favor of physician charges so querying the UB–04 data for such cases would retrieve an incomplete patient population and would exclude non-Medicare patients. One commenter suggested that CMS wait until the meaningful use implementation of EHRs is completed before requiring the reporting of population and sampling data because this would eliminate the burden on hospital staff to pull data from multiple sources to obtain population size. One commenter stated that it foresaw the implementation of the population and sample data reporting requirement as extremely problematic.

Response: We understand the commenters' concerns that outpatient billing could be more varied and less defined than inpatient billing and that there could be issues with charge write-offs and other billing factors that could complicate a hospital's determination of outpatient population sizes. We acknowledge that the adoption of EHRs could facilitate the determination of outpatient population sizes. We also acknowledge that we have seen evidence that some hospitals would not be able to meet the reporting of population and sampling size requirement due to issues such as the information being located in multiple areas. We have noted this issue in previous rulemaking (74 FR 60645). We note that the HOP QDRP is entering its third year of quality data reporting and believe that it would be beneficial for hospitals to develop systems that can determine their population sizes for

outpatient quality measures so they can assess their completeness of reporting and accuracy of their sample size selections.

However, after consideration of the public comments we received, we have decided to not finalize our proposal to require the reporting of population and sample size data and instead continue our policy of accepting the submission of this information on a voluntary basis for the CY 2012 payment determination. In the past we have recognized that collecting this information can be burdensome and time consuming for some hospitals for their outpatient populations. Based upon the comments we received, we are convinced that these issues remain for a significant number of hospitals.

For all other CY 2011 proposals for general data collection and submission requirements (that is, those proposals aside from the population and sampling data reporting requirement), we did not receive any comments and we are finalizing these proposals without modification.

b. Extraordinary Circumstance Extension or Waiver for Reporting Quality Data

In our experience, there have been times when hospitals have been unable to submit required quality data due to extraordinary circumstances that are not within their control. It is our goal to not penalize hospitals for such circumstances and we do not want to unduly increase their burden during these times. Therefore, in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60046 through 600647), we adopted a process for hospitals to request and for CMS to grant extensions or waivers with respect to the reporting of required quality data when there are extraordinary circumstances beyond the control of the hospital. In the CY 2011 OPPS/ASC proposed rule (75 FR 46379), we proposed to retain these procedures with some proposed modifications.

Under the process, in the event of extraordinary circumstances, such as a natural disaster, not within the control of the hospital, for the hospital to receive consideration for an extension or waiver of the requirement to submit quality data for one or more quarters, a hospital would submit to CMS a request form that would be made available on the QualityNet Web site. The following information should be noted on the form:

- Hospital CCN;
- Hospital Name;
- CEO and any other designated personnel contact information, including name, e-mail address, telephone number, and mailing address (must include a physical address; a post office box address is not acceptable);
- Hospital's reason for requesting an extension or waiver;
- Evidence of the impact of the extraordinary circumstances, including but not limited to photographs, newspaper and other media articles; and
- A date when the hospital would again be able to submit HOP QDRP data, and a justification for the proposed date.

The request form would be signed by the hospital's CEO. A request form would be required to be submitted within 45 days of the date that the extraordinary circumstance occurred. We proposed to remove the requirement found in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60646) that the hospital include an identified reason for requesting an extension or waiver in addition to the hospital's reason for requesting an extension or waiver as a requirement. We believe that this requirement is redundant and removing it will reduce unnecessary hospital burden.

Following receipt of such a request, CMS would—

(1) Provide a written acknowledgement using the contact information provided in the request, to the CEO and any additional designated hospital personnel, notifying them that the hospital's request has been received;

(2) Provide a formal response to the CEO and any additional designated hospital personnel using the contact information provided in the request notifying them of our decision; and

(3) Complete any CY 2011 request for Extraordinary Circumstance Extension or Waiver for Reporting Quality Data requests reviews and communicate the results of these determinations within 90 days following our receipt of such a request. We proposed to add a deadline for a CMS response so that hospitals can have a designated timeline for when they should receive such a response.

This proposal would not preclude us from granting waivers or extensions to hospitals that have not requested them when we determine that an extraordinary circumstance, such as an act of nature (for example, hurricane) affects an entire region or locale. If we make the determination to grant a waiver or extension to hospitals in a region or locale, we would communicate this decision to hospitals and vendors through routine communication channels, including but not limited to e-mails and notices on the QualityNet Web site. We invited public comment on these proposals.

We did not receive any public comments on our CY 2011 proposals for extraordinary circumstance extensions or waivers for the reporting of quality data under the HOP QDRP; therefore, we are finalizing our proposals without modification.

3. HOP QDRP Validation Requirements for Chart-Abstracted Data: Data Validation Approach for CY 2012 and Subsequent Years

a. Background

In the CY 2010 OPPS/ASC proposed rule, we solicited public comments on our proposed validation methodology (74 FR 35403 through 35404). We stated that we are considering building upon what we proposed as a validation approach for CY 2012 and subsequent years by, in addition to selecting a random sample of hospitals for validation purposes, selecting targeted hospitals based on criteria designed to measure whether the data they have reported raises a concern regarding data accuracy. These possible targeting criteria included identified abnormal data patterns, whether a hospital had previously failed validation, whether a hospital had not been previously selected for validation for 2 or more consecutive years, and some combination of some or all of the criteria.

We solicited public comments on whether such criteria, or another approach, should be applied in future years. We especially solicited suggestions for additional criteria that could be used to target hospitals for validation. We greatly appreciate all the public comments we received regarding the validation process proposed for CY 2012 and subsequent years. We responded to public comments on our proposed methodology for CY 2012 and subsequent years but did not finalize a validation process in the CY 2010 OPPS/ASC final rule with comment period 74 FR 60650 through 60652). We noted that we would take all of the comments we received into account when we develop our validation proposals for CY 2012.

b. Data Validation Requirements for CY 2012

In the CY 2011 OPPS/ASC proposed rule (75 FR 46379 through 46381), similar to our proposed and adopted validation plan for the FY 2012 Hospital Inpatient Quality Reporting Program, we proposed to validate data from 800 randomly selected hospitals (approximately 20 percent of all participating HOP QDRP hospitals) each year, beginning with CY 2012 payment determination. We proposed to sample 800 hospitals because we believe, based

upon sampling simulation studies using HOP QDRP data, that sampling this number would provide a sufficient number for a representative sample of hospitals on various strata (for example, urban, rural, bed-size) while significantly reducing overall hospital burden. For the CY 2012 payment determination, we would select only from hospitals participating for the CY 2012 payment update, so if a hospital submitted data for the CY 2011, but withdrew, this hospital would not be deemed as eligible for selection. We noted that because 800 hospitals would be selected randomly, every HOP QDRP-participating hospital would be eligible each year for validation selection.

For each selected hospital, we proposed to randomly select up to a total of 48 self-reported cases from the total number of cases (12 per quarter) that the hospital successfully submitted to the OPPS Clinical Warehouse. However, if a selected hospital has submitted less than 12 cases in any quarter, only those cases available would be validated. We believe that validating a larger number of cases per hospital, but only for 800 randomly selected hospitals, and validating these cases at the measure level (rather than the data element level) has several benefits. We proposed up to a total of 48 cases per hospital because a sample size of about 50 is considered sufficient for detecting relationships and correlations, so a larger sample size is not deemed necessary (for reference, see Wilson Van Voohis, Carmen R. and Morgan, Betsey L., (2007), *Understanding Power and Rules of Thumb for Determining Sample Sizes, Tutorials in Quantitative Methods for Psychology*, Volume 3(2), Pages 43–50). We believe that this approach is suitable for HOP QDRP data because it will: Produce a more reliable estimate of whether a hospital's submitted data have been abstracted accurately; provide more statistically reliable estimates of the quality of care delivered in each selected hospital as well as at a national level; and reduce overall hospital burden because most hospitals will not be selected to undergo validation each year.

We would not be selecting cases stratified by measure or topic; our interest is whether the data submitted by hospitals accurately reflect the care delivered and documented in the medical record, not what the accuracy is by measure or whether there are differences by topic. Additionally, we note that, due to the distribution of HOP QDRP data submitted to date by hospital size, the data do not lend themselves to sampling by topic area. Specifically, small hospitals tend to have more AMI Cardiac Care cases and fewer Surgical Care cases, whereas, larger hospitals tend to have few if any AMI Cardiac Care cases and more Surgical Care cases.

Analysis of submitted HOP QDRP data indicate that this sampling design would provide sufficient number of denominator cases per measure for determination of national and individual hospital measure estimates with acceptable levels of statistical certainty.

We proposed to sample data for April 1, 2010 to March 31, 2011 services because this would provide a full year of the most recent data possible to use for the purpose of completing the validation in sufficient time for us to make the CY 2012 payment determinations.

A designated CMS contractor would, each quarter that applies to the validation, ask each of the 800 selected hospitals to submit medical documentation for up to 12 randomly selected cases submitted to and accepted by the HOP QDRP Clinical Warehouse. The CMS contractor would request paper copies of medical documentation corresponding to selected cases from each hospital via certified mail or other trackable method that requires a hospital representative to sign for the request letter; a trackable method would be utilized so that CMS would be assured that the hospital received the request. The hospital would have 45 calendar days from the date of the request as documented in the request letter to submit the requested documentation and have the documentation received by the CMS contractor. If the hospital does not comply within 30 calendar days of receipt of the initial medical documentation request, the CMS contractor would send a second letter by certified mail or other trackable method to the hospital, reminding the hospital that paper copies of the requested documentation must be submitted and received within 45 calendar days following the date of the initial CMS contractor request. If the hospital does not submit the requested documentation and the documentation is not received by the CMS contractor within the 45 calendar days, then the CMS contractor would assign a "zero" score to each data element for each selected case and the case would fail for all measures in the same topic (for example, OP–6 and OP–7 measures for a Surgical Care case).

We proposed that the letter from the designated CMS contractor would be addressed to the hospital's medical record staff identified by the hospital for the submission of records under the Hospital Inpatient Quality Reporting Program (that is, the hospital's medical records staff identified by the hospital to their State QIO). If CMS has evidence that the hospital received both letters requesting medical records, the hospital would be deemed responsible for not returning the requested medical record documentation and the hospital would not be allowed to submit such medical documentation as part of its reconsideration request so that information not utilized in making a payment determination is not included in any reconsideration request.

Once the CMS contractor receives the requested medical documentation, the contractor would independently reabstract the same quality measure data elements that the hospital previously abstracted and submitted, and the contractor would then compare the two sets of data to determine whether the two sets of data match. Specifically, the contractor would conduct a measures level validation by calculating each measure within a submitted case using the independently reabstracted data and then comparing this to the measure reported by the hospital; a percent agreement would then be calculated. Specifically, the validation score for a hospital would equal the total number of measure matches divided by the total number of measures multiplied by 100 percent.

This method is the same as recommended in the CMS Hospital Value-Based Purchasing Report to Congress and is illustrated more fully on pages 83–84 of this report which can be found on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf.* We believe that this approach is appropriate and it was supported by many commenters when we requested comment on HOP QDRP validation requirements outlined in the CY 2010 OPPS/ASC proposed rule (74 FR 35402 through 35403; 74 FR 60647 through 60652).

To receive the full OPPS payment update, we proposed that hospitals must attain at least a 75 percent validation score, based upon our validation process, for the designated time period. We have selected 75 percent as the threshold for the validation score because we believe this level is reasonable for hospitals to achieve while still ensuring accuracy of the data. Additionally, this level is consistent with what we proposed and adopted for the Hospital Inpatient Quality Reporting Program (75 FR 23993 and 75 FR 50226). Since we are not validating all hospital measures submitted, it is necessary to calculate a confidence

interval that incorporates sampling error. We would use the upper bound of a one-tailed 95 percent confidence interval to estimate the validation score. We proposed to use a one-tail confidence interval to calculate the validation score because it appropriately reflects our concern of whether the confidence interval for the calculated validation score includes or is above the 75 percent validation threshold for a hospital to be considered as submitting accurate data. If the calculated upper limit is above the required 75 percent validation score threshold, we would consider a hospital's data to be "validated" for payment purposes. The use of a one-tailed confidence interval and the 75 percent and threshold level are the same as those finalized for the Hospital Inpatient Quality Reporting Program for FY 2012 payment determinations (75 FR 23991 through 23993).

For derivation of the upper bound of a one-tailed 95 percent confidence interval we proposed to use a binomial distribution approach as we are looking at the percentage of measures submitted by a hospital matching what is calculated from the reabstracted data. Since the measure match rate for each hospital is a proportion, a binomial approach is appropriate, see Pagano, Robert R., (1990), *Understanding Statistics in the Behavioral Sciences,* 3rd Edition, Pages 175–188.

Thus, we proposed the following formula which includes a finite population correction factor and a continuity correction factor for calculating the upper bound of the one-tailed 95 percent confidence interval:

$$\textbf{Upper Confidence Limit} = p + 1.645\left(\sqrt{\frac{p\,(1-p)}{n}}\right)\left(\sqrt{\frac{N-n}{N-1}}\right)+\frac{1}{2n}$$

In this formula, N represents the population for the reporting year, n represents the sample size for the reporting year, p (calculated as a percentage) represents the validation score for the reporting year (that is, the percentage of measures matching), and 1-p represents the percentage of measures not matching. It should be noted that a confidence interval would not need to be calculated for hospitals that did not have enough cases to sample as the confidence interval is equal to zero (when the value of N is equal to n, N minus n equals zero and the upper confidence limit is equal to the validation score in the above formula). In addition, a confidence interval would not need to be calculated for those hospitals that have a validation score, p, that is greater than or equal to 75 percent because the hospital has attained the minimum threshold; the upper bound of any calculated confidence interval would be 75 percent or greater.

For further information on the proposed methodology for calculation of a 95 percent confidence interval for a binomial distribution utilizing a finite population correction, see *http://itl.nist.gov/div898/handbook/prc/section2/prc24.htm* and *http://courses.wcupa.edu/rbove/Berenson/10th%20ed%20CD-ROM%20topics/section7_3.pdf.*

We solicited public comments on this proposed validation methodology. The public comments we received and our responses are outlined below.

Comment: Several commenters supported the proposal to validate the accuracy of a hospital's measurement rate rather than on individual data elements and stated that by focusing on the hospital's measure rate, CMS is focusing on the information most important to patient care.

Response: We thank the commenters and appreciate their support. We agree that by utilizing a match rate at the measure level, we are focusing on the information most relevant to measuring the accuracy of this data which is important to patient care.

Comment: Several commenters supported the proposed validation approach of reviewing 48 medical charts (12 per quarter) from 800 randomly selected hospitals each year with the review assessing the accuracy of each hospital's measure rate, reflecting whether or not the hospital classified patients appropriately into the measure denominators and numerators. Some of these commenters stated their belief that this approach holds promise as a reasonable approach to ensure the accuracy of the data.

Response: We thank the commenters and appreciate their support. We agree with the commenters that the proposed validation process beginning with CY 2012 is an improved and reasonable approach for ensuring data accuracy. We also agree that a validation process is important in public reporting of quality data and believe that consistency between quality data reporting programs is important. Regarding the commenters who stated that our proposed validation method for assessing accuracy reflects whether or not the hospital classified patients appropriately into the measure denominators and numerators, we want to clarify that what we are assessing is whether, for each selected hospital-reported measure, the data that the hospital reported matches what is determined by independent abstraction. We are not assessing whether the hospital classified patients appropriately into the measure denominators and numerators.

Comment: One commenter disagreed with the random sampling of hospitals methodology and believed that all hospitals should be held accountable equally via a valid sample based on local practice patterns. This commenter also urged CMS to delegate targeted reviews to the State QIOs on a more proactive basis so that they are addressed in a more immediate timeframe, not leaving it to chance that a hospital with poor data quality will be identified randomly.

Response: Under the HOP QDRP, all hospitals are responsible for submitting accurate data. Because all reporting hospitals will be subject to selection for validation each payment determination year, we believe that all hospitals will have incentive to maintain data quality. Regarding the use of State QIOs in performing targeted reviews, the HOP QDRP was implemented separately from the QIO program and State QIOs have not been involved with the HOP QDRP to date. We note that we intend to provide support for data quality issues to individual hospitals through existing support mechanisms, including QualityNet reports and existing support contractors. In addition, we have included criteria aimed at data quality concerns among our targeting criteria for data validation conditions under consideration for CY 2013 and subsequent years.

Comment: Several commenters agreed with having a minimum of 75 percent reliability from chart abstraction for hospitals to pass validation. These commenters stated their view that adopting the same approach regarding validation for the inpatient and

outpatient quality measure programs enhanced consistency between the two programs. One commenter supported the proposed validation program for outpatient data reporting as it is harmonized with the inpatient program. One commenter stated its recognition of the important role of validation in the public reporting process and because the proposed process mirrors some of the current validation processes they supported the proposed approach.

Response: We thank the commenters and appreciate their support. We agree that consistency between quality data reporting programs is important. We note that we strive to maintain consistency between the inpatient and outpatient data reporting programs, with differences occurring due to differences in data or data systems between the programs.

Comment: One commenter stated that the proposed validation requirements are reasonable and would be acceptable to providers if it were the only Federal data submission requirement. This commenter was concerned that the record requests for validation would supplement those already established as part of Federal integrity audit processes (for example, RAC, Medicaid Integrity, ZPIC, and MAC) and facilities would receive multiple requests from each contracted entity significantly increasing hospital provider's labor investment and costs. This commenter urged CMS to review the validation process with respect to other data requirements rather than seeing it as a single request, and to consider the operational impact that receiving multiple audit entity requests will have on any single provider.

Response: We understand the commenter's concern regarding multiple Federal medical record requests. For HOP QDRP validation, we have worked to limit overall burden by reducing the number of hospitals participating annually in validation through our random sampling of hospitals. In addition, hospitals will be reimbursed for photocopying and mailing costs as they are under the Hospital Inpatient Quality Reporting Program, thus, reducing the burden in submitting medical record documentation for HOP QDRP validation purposes. We agree that efforts should be made to keep record requests for validation purposes at the minimum necessary to ensure accuracy of submitted data and will consider ways to do so in future rulemaking.

Comment: Some commenters asked if their assumption that validation of the Imaging Efficiency measures would not be required as part of the data validation process since the analysis is done through claims data is correct.

Response: The commenters' assumption is correct. Validation of the Imaging Efficiency measures would not be required as part of the data validation process because that process, at the present time, only applies to chart-abstracted measures.

Comment: One commenter recommended a phased-in approach, with the first year being a "test run" to allow hospitals the opportunity to become familiar with the HOP QDRP validation program.

Response: We believe the commenter is asking CMS to allow hospitals to first receive experience with the validation process without their payment being affected. We also believe that our validation process for the CY 2011 payment determination (74 FR 60647 through 60648) fulfills this recommendation.

After consideration of the public comments we received we are adopting as final, without modification, our proposals regarding validation for the CY 2012 payment determination.

c. Additional Data Validation Conditions under Consideration for CY 2013 and Subsequent Years

In the CY 2011 OPPS/ASC proposed rule (75 FR 46381), we stated that we are considering building upon what we proposed as a validation approach for the HOP QDRP. We are considering, in addition to selecting a random sample of hospitals for validation purposes, selecting targeted hospitals based on criteria designed to measure whether the data they have reported raises a concern regarding data accuracy. Because hospitals have gained little experience with validation under the HOP QDRP, we are considering this approach for possible use beginning with the CY 2013 payment determination. Examples of targeting criteria could include:

- Abnormal data patterns identified such as consistently high HOP QDRP measure denominator exclusion rates resulting in unexpectedly low denominator counts;
- Whether a hospital had previously failed validation;
- Whether a hospital had not been previously selected for validation for 2 or more consecutive years;
- Whether a hospital had low submitted case numbers relative to population sizes; and/or
- Whether a hospital had any extreme outlier values for submitted data elements.

We invited comment on whether, in addition to random sampling for validation, we should use targeted validation and, if so, what criteria for targeting we should adopt.

Comment: One commenter believed that no single hospital should be at risk for being selected for validation for multiple years and that targeting criteria should be used to ensure that hospitals are not over-selected.

Response: We understand the commenter's concern that hospitals could be selected for validation in multiple years due to the use of targeting criteria. We will take this comment into consideration as we consider whether to propose targeting criteria that could result in a hospital being selected for validation for multiple years as a part of the validation process.

We thank the commenters for their views on these issues and will take them into account when considering further criteria for the validation process for CY 2013 and subsequent years. We note that for the CY 2013 payment determination, HOP QDRP quality data reporting will have been completed for four payment determinations: CYs 2009, 2010, 2011, and 2012. Further, hospitals will have had the opportunity to learn from the validation process for the CY 2011 and CY 2012 payment determinations. We also believe that all of the targeting criteria we discuss above are reasonable. We intend to propose targeting criteria in the validation process for CY 2013 and subsequent years in our CY 2012 OPPS/ASC proposed rule.

E. HOP QDRP Reconsideration and Appeals Procedures

When the Hospital Inpatient Quality Reporting Program was initially implemented, it did not include a reconsideration process for hospitals. Subsequently, we received many requests for reconsideration of those payment decisions and, as a result, established a process by which participating hospitals would submit requests for reconsideration. We anticipated similar concerns with the HOP QDRP and, therefore, in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875), we stated our intent to implement for the HOP QDRP a reconsideration process modeled after the reconsideration process we implemented for the Hospital Inpatient Quality Reporting Program. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68779), we adopted a mandatory reconsideration process that applied to the CY 2010 payment decisions. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60654 through

60655), we continued this process for the CY 2011 payment update. In the CY 2011 OPPS/ASC proposed rule (75 FR 46381 through 46382), we proposed to continue this process for the CY 2012 payment update with some modification. Under this proposed process, the hospitals must—

• Submit to CMS, via QualityNet, a Reconsideration Request form that would be made available on the QualityNet Web site; this form would be submitted by February 3, 2012, and would contain the following information:

oo Hospital CCN.

oo Hospital Name.

oo CMS-identified reason for failure (as provided in any CMS notification of failure to the hospital).

oo Hospital basis for requesting reconsideration. This would identify the hospital's specific reason(s) for believing it met the HOP QDRP requirements and should receive a full annual payment update.

oo CEO and any additional designated hospital personnel contact information, including name, e-mail address, telephone number, and mailing address (must include physical address, not just a post office box).

oo A copy of all materials that the hospital submitted in order to receive the full payment update for CY 2012. Such material would include, but may not be limited to, the applicable Notice of Participation form or completed online registration form, and quality measure data that the hospital submitted via QualityNet.

• Submit paper copies of all the medical record documentation that it submitted for the initial validation. Hospitals would submit this documentation to a designated CMS contractor which would have authority to review patient level information. We would post the address where hospitals are to ship this documentation on the QualityNet Web site. Final review of all mismatched data under a reconsideration request would be done by CMS.

• Provide a written justification for each appealed data element classified during the validation process as a mismatch. Only data elements that affect a hospital's validation score would be subject to reconsideration. We would review the data elements that were labeled as mismatched as well as the written justifications provided by the hospitals, and make a decision on the reconsideration request.

For CY 2011 reconsiderations, we required that a reconsideration request must be signed by the hospital CEO (74 FR 60654). However, we have found that this requirement increases the burden for hospitals as it hampers the electronic submission of the HOP QDRP reconsideration request form. Thus, we did not propose to include this requirement; for CY 2012 reconsiderations, reconsideration request forms would not need to be signed by the hospital's CEO.

Following receipt of a request for reconsideration, CMS would—

• Provide an e-mail acknowledgement, using the contact information provided in the reconsideration request, to the CEO and any additional designated hospital personnel notifying them that the hospital's request has been received.

• Provide a formal response to the hospital CEO and any additional designated hospital personnel, using the contact information provided in the reconsideration request, notifying the hospital of the outcome of the reconsideration process.

We intend to complete any CY 2012 reconsideration reviews and communicate the results of these determinations within 90 days following the deadline for submitting requests for reconsideration. In the CY 2010 OPPS/ASC final rule with comment period 74 FR 60654 through 60655), in response to a comment, we indicated that we would "complete any reconsideration reviews and communicate the results of these determinations within 60 to 90 days following the date we receive the request for reconsideration." In the CY 2011 OPPS/ASC proposed rule (75 FR 46382), we proposed to refine how we describe the time frame for CY 2011 from "60 to 90 days" to within "90 days" because designating a range of dates is unnecessary for this provision.

If a hospital is dissatisfied with the result of a HOP QDRP reconsideration decision, we proposed that the hospital may file an appeal under 42 CFR Part 405, Subpart R (PRRB appeal).

Similar to what we proposed and finalized for the Hospital Inpatient Quality Reporting Program, the scope of our review when a hospital requests reconsideration because it failed our validation requirement would be as follows:

• Hospital requests reconsideration for CMS contractor-abstracted data elements classified as mismatches affecting validation scores. Hospitals would be required to have timely submitted requested medical record documentation to the CMS contractor during the quarterly validation process for the requested case to be eligible to be reconsidered on the basis of mismatched data elements.

• Hospital requests reconsideration for medical records submitted during the quarterly validation process and classified as invalid record selection. Invalid record selections would be defined as medical records submitted by hospitals during the quarterly validation process that do not match the patient's episode of care information as determined by the designated re-abstracting CMS contractor. In other words, the contractor determines that the hospital returned medical documentation that is different from that which was requested. If this designated contractor determines that the hospital submitted invalid or incorrect medical documentation, it would award a zero validation score for the case. During the reconsideration process, our review of invalid record selection would initially be limited to determining whether the medical documentation submitted initially to the designated CMS contractor was for the designated episode of care. If we determine during reconsideration that the hospital did submit medical documentation corresponding to the designated episode of care, then we would abstract data elements from the medical record documentation submitted by the hospital; otherwise, the case would not be abstracted.

• Hospital requests reconsideration for medical records not submitted to the CMS contractor within the 45 calendar day deadline. Our review would initially be limited to determining whether the CMS contractor received the requested medical record documentation within 45 calendar days, and whether the hospital received the initial medical record request and reminder notice. If we determine during reconsideration that the CMS contractor did receive the paper copy of the requested, supporting medical record documentation within 45 calendar days, then we would abstract data elements from the medical record documentation submitted by the hospital. If we determine that the hospital received two letters requesting medical documentation and still did not submit the requested documentation within the 45 calendar day period, CMS would not accept this documentation as part of the reconsideration and CMS would not abstract data from this documentation.

In sum, we proposed to initially limit the scope of our reconsideration reviews involving validation to information already submitted by the hospital during the quarterly validation process, and we would not abstract submitted medical record documentation that was not submitted to the CMS contractor during the quarterly validation process.

We would expand the scope of our reconsideration reviews involving validation only if we find during the initial review that the hospital correctly and timely submitted the requested medical record documentation; only then would we abstract data elements from the medical record documentation submitted by the hospital as part of our reconsideration review.

If a hospital is dissatisfied with the result of a HOP QDRP reconsideration decision, the hospital would be able to file an appeal under 42 CFR Part 405, Subpart R (PRRB appeal).

We did not receive any public comments on our CY 2012 proposals for HOP QDRP reconsideration and appeals procedures; therefore, we are finalizing our proposals without modification.

F. Reporting of ASC Quality Data

As discussed above, section 109(b) of the MIEA–TRHCA amended section 1833(i) of the Act by redesignating clause (iv) as clause (v) and adding new clause (iv) to paragraph (2)(D) and by adding new paragraph (7). These amendments authorize the Secretary to require ASCs to submit data on quality measures and to reduce the annual payment update in a year by 2.0 percentage points for ASCs that fail to do so. However, these provisions permit, but do not require, the Secretary to take such action.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875), the CY 2009 OPPS/ASC final rule with comment period (73 FR 68780), and the CY 2010 OPPS/ASC final rule with comment period (74 FR 60656), we indicated that we intend to implement the provisions of section 109(b) of the MIEA–TRHCA in a future rulemaking. While promoting high quality care in the ASC setting through quality reporting is highly desirable and fully in line with our efforts under other payment systems, the transition to the revised payment system in CY 2008 posed significant challenges to ASCs, and we determined that it would be most appropriate to allow time for ASCs to gain some experience with the revised payment system before introducing other new requirements. Further, by implementing quality reporting under the OPPS prior to establishing quality reporting for ASCs, CMS would gain experience with quality measurement in the ambulatory setting in order to identify the most appropriate measures for quality reporting in ASCs prior to the introduction of the requirement for ASCs. Finally, we are sensitive to the potential burden on ASCs associated with chart abstraction and believe that adopting such measures at this time is in contrast with our desire to minimize collection burden, particularly when measures may be reported via EHRs in the future.

We continue to believe that promoting high quality care in the ASC setting through quality reporting is highly desirable and fully in line with our efforts under other payment systems. However, we continue to have the concerns outlined above for CY 2011. In the CY 2011 OPPS/ASC proposed rule (75 FR 46383), we stated that we intend to implement the provisions of section 109(b) of the MIEA–TRHCA in a future rulemaking. We invited public comment on: (1) The deferral of quality data reporting for ASCs; (2) suggestions for quality measures geared toward the services provided by ASCs; and (3) potential reporting mechanisms for ASC quality data, including electronic submission of these data. In addition, we invited public comment on the following measures under future consideration for ASC quality data reporting:

- Patient Fall in the ASC;
- Patient Burn;
- Hospital Transfer/Admission;
- Wrong Site, Side, Patient, Procedure, Implant;
- Prophylactic IV Antibiotic Timing;
- Appropriate Surgical Site Hair Removal;
- Surgical site infection (SSI);
- Medication administration variance (MAV);
- Medication reconciliation; and
- VTE measures: Outcome/assessment/prophylaxis.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46383), we note that section 3006(f) of the Affordable Care Act, added by section 10301(a) of the Affordable Care Act, requires CMS to develop a plan to implement a value-based purchasing program for ASCs; this plan is due to Congress by January 1, 2011. We stated that we intend to align implementation of ASC quality reporting to be consistent with the value-based purchasing plan that will be developed and that we intend to propose implementing the provisions of section 109(b) of the MIEA–TRHCA in CY 2012 rulemaking. We invited public comment on: (1) The timing of implementing quality data reporting for ASCs; (2) suggestions for quality measures for services provided by ASCs; and (3) potential reporting mechanisms for ASC quality data, including electronic submission of these data.

Comment: Several commenters agreed with CMS' intention to defer quality data reporting for ASCs. Some commenters supported CMS's rationale for the approach, that is, enabling ASCs to gain experience with the recently launched payment system and permitting CMS to gain experience in the HOPD setting before implementing quality data reporting requirements for ASCs. Several commenters supported CMS' decision to move with caution in expanding quality data reporting to the ASC setting and appreciated CMS' sensitivity to administrative burdens faced by ASCs. Commenters stated that it would be beneficial to allow extra time in planning a quality data reporting program for ASCs in order to assess implementation challenges and identify appropriate measures.

Response: We thank the commenters for their support for delaying quality data reporting for ASCs and their agreement with our reasons for doing so.

Comment: Numerous commenters urged CMS to begin the ASC quality data reporting program as soon as possible. Many commenters indicated that the collection and reporting of quality data is a common practice for ASC facilities, as 35 States are currently collecting ASC quality data. The industry is eager to make quality data available to consumers in a manner that facilitates direct comparisons between equivalent surgical care delivered in HOPDs and ASCs. Some commenters urged CMS to implement a quality data reporting system for ASCs, out of concern that data has shown there are common occurrences of lapses in infection control in ASCs in three States. One commenter was concerned about the continued delay in a quality measurement and reporting program for the rapidly growing ASC setting and indicated that, by now, it should be technically feasible for ASCs to report on quality measures. One commenter recommended the adoption of NQF-endorsed electronic measures and limiting implementation to no more than three measures in the first reporting year. The commenter also urged CMS to keep the results of ASC quality reporting confidential for the first year.

Response: We recognize that it is beneficial for consumers to be able to compare the quality of surgical care across HOPDs and ASCs. We intend to begin this reporting program as soon as it is feasible. We thank the commenters for these suggestions. We will take them into consideration in the planning process for ASC quality measure data reporting.

Comment: One commenter stated that the use of EHRs in ASCs is still not widespread, so CMS should consider alternative reporting mechanisms such as registry-based reporting.

Response: We thank the commenter for the suggestion and we will evaluate the feasibility of alternative reporting mechanisms, such as registry-based reporting, for ASCs in conjunction with using EHR technology.

Comment: One commenter encouraged CMS to align potential ASC quality measure metrics with State and Federal legislative requirements as well as consider some inpatient measure collection process for applicability. One commenter recommended that a future ASC quality reporting program should: (1) Provide a mechanism for providers to raise concerns prior to public display of information; (2) include a provider narrative section to inform consumers of the reliability or accuracy of the information presented; and (3) include facility accreditation status, state licensure and Medicare certification.

Response: We thank the commenters for their input. We will take the comments into consideration in the planning process for ASC quality measure data reporting.

As stated previously, we invited public comment on 10 quality measures under future consideration for ASC quality data reporting (75 FR 46383). We received the following comments on these quality measures:

Comment: One commenter supported the Patient Fall measure.

Response: We thank the commenter for the support. We will consider it in the planning process for ASC quality measure data reporting.

Comment: One commenter supported the Patient Burn measure.

Response: We thank the commenter for the support. We will consider it in the planning process for ASC quality measure data reporting.

Comment: One commenter supported the Hospital Transfer/Admission measure. Another commenter stated that this measure only measures transfer/admission status which is controlled by insurance companies and not by ASCs. The commenter recommended the exclusion of this measure in ASC reporting program.

Response: We thank the commenters for the input. We will consider it in the planning process for ASC quality measure data reporting.

Comment: Two commenters supported the Prophylactic IV Antibiotic Timing measure.

Response: We thank the commenters for the support. We will consider it in the planning process for ASC quality measure data reporting.

Comment: Two commenters supported the Appropriate Surgical Site Hair Removal measure.

Response: We thank the commenters for the support. We will consider it in the planning process for ASC quality measure data reporting.

Comment: One commenter supported the Surgical Site Infection (SSI) measure. Two commenters stated the tracking of surgical complications is resource intensive and the accuracy of reporting of post-operative surgical site infections is resource-dependent. One commenter stated the measure involves many procedures and variables. The commenter recommended that CMS learn from the implementation of SSI measures in the Hospital Inpatient Quality Reporting Program, with respect to definition standardization, data collection and data validation. One commenter suggested using one single set of SSI measures to track SSI continuum across hospital inpatient, hospital outpatient and ASC settings. The commenter also indicated the review of diagnosis/services on claim data, antibiotic prescribed within 30 days of a surgical procedure, and post-surgical visits could be used for ASC pay-for-performance metrics. One commenter recommended the exclusion of this measure in ASCs.

Response: We thank the commenters for the support and suggestions. We will consider them in the planning process for ASC quality measure data reporting.

Comment: One commenter supported the VTE measures: Outcome/assessment/prophylaxis. Two commenters recommended postponing the VTE measures until there is more evidence to support the measure.

Response: We thank the commenters for the support and suggestions. We will consider them in the planning process for ASC quality measure data reporting.

Comment: Two commenters suggested the adoption of hospital measures that are applicable in the ASC settings: (1) Selection of prophylactic antibiotic; and (2) presence of physician during entire recovery period.

Response: We thank the commenters for the suggestions. We will consider them in the planning process for ASC quality measure data reporting.

Comment: Some commenters recommended additional measures and measure topics for ASCs:

- Sedation safety (rescue required, delayed recovery)
- Patient experience/satisfaction
- 6 NQF-endorsed, ASC QC-developed, facility-level measures
- Wrong Site/wrong side/wrong patient/wrong procedure/wrong implant
- Timing of the administration of intravenous antibiotics for prophylaxis of surgical site infection
- Infection control
- HAC

Response: We thank the commenters for the recommendations. We will consider them in the planning process for ASC quality measure data reporting.

Comment: Several comments supporting the implementation of a value-based purchasing program for ASCs. One commenter stated that CMS should engage all stakeholders to preview the ASC value-based purchasing report prior to its submission to Congress on January 1, 2011. One commenter recommended that CMS start ASC quality reporting in the HOP QDRP in CY 2012 to prepare for ASC value-based purchasing for ASCs.

Response: Section 3006(f) of the Affordable Care Act, added by section 10301(a) of the Affordable Care Act, requires the Secretary to develop a plan to implement a value-based purchasing program for ASCs. In developing the plan, the Secretary must consult with relevant affected parties. We are aware that, in order to implement any such plan, a quality reporting program must be initiated. We thank the commenters for their support and recommendations.

After consideration of the public comments we received, we are restating our intent to propose implementing an ASC quality measure reporting program in the CY 2012 proposed rule. We continue to believe that promoting high quality care in the ASC setting through quality data reporting is highly desirable and fully in line with our efforts under other payment systems.

G. Electronic Health Records

As we stated in the CY 2010 OPPS/ASC final rule (74 FR 60656), we are actively seeking alternatives to manual chart abstraction for the collection of quality measures for our quality data reporting programs. Among these alternatives are claims-based measure calculations, collection of data from systematic registries widely used by hospitals, and electronic submission of quality measures using EHRs. In response to the CY 2009 OPPS/ASC final rule (73 FR 68769), we received suggestions during the public comment period that we adopt measures that can be collected via EHRs. We agree with the commenters about the importance of actively working to move to a system of data collection based on submission from EHRs. In section XVI.B.5.b. of this final rule with comment period, for the CY 2014 payment determination we stated that we were considering for the future several chart-abstracted quality measures for diabetes mellitus, some of which have already been specified for EHR-based capture and submission, and

others for which EHR-based submission is planned. We have been engaged with health IT standard-setting organizations to promote the development of the necessary standards regarding data capture to facilitate data collection via EHRs, and have been collaborating with such organizations on standards for a number of quality measures. We encourage hospitals to take steps toward the adoption of EHRs that will allow for reporting of clinical quality data from the EHR directly to a CMS data repository. We also encourage hospitals that are implementing, upgrading, or developing EHR systems to ensure that such systems conform to standards adopted by HHS. We invited public comment on the future direction of EHR-based quality measurement submission.

Comment: Some commenters strongly urged CMS to adopt quality measures that have electronic specifications. Commenters supported the use of EHRs and other health information technology (IT) and encouraged CMS to collaborate with the HHS Office of the National Coordinator on Health IT (ONC) to further advance such efforts. The commenters recognized the capability and the huge benefits from such technology. Commenters commended CMS for encouraging the development and adoption of uniform data content and information technology standards across the health care industry that will support automated data collection and reporting of clinical data from EHR systems. The commenters believed that such efforts would streamline hospital data submission procedures and significantly reduce the burden for hospitals.

One commenter noted that the availability of e-measures is still limited. For instance, the commenter believes that it is difficult to find EHR systems that can easily interface with disease registries. Some commenters encouraged CMS to consider postponing the adoption of new quality measures for the HOP QDRP for CY 2012 until those measures can be collected via EHRs. The commenters noted that delaying the adoption of new measures for this reason was also warranted given the challenges hospitals will face in implementing ICD–10 coding system and complying with the Affordable Care Act.

Response: We appreciate the supportive comments we received regarding EHR-based data collection as an alternative data source for quality measures. We agree that EHR-based data submission may provide an alternative means of submitting quality data that would reduce the burden of chart abstraction for hospitals. Although we encourage hospitals to adopt EHRs, we acknowledge the challenges that must be met both by hospitals and CMS to establish the infrastructure and interoperability necessary to collect data on quality measures via EHRs. We also recognize the burden faced by hospitals in making multiple technological changes, including the ICD–10 coding system, and complying with the Affordable Care Act. We will carefully consider any additional burden that may be imposed on hospitals as a result of adopting additional measures for the HOP QDRP and will continue to consider other feasible alternatives to data collection such as registries. We will also continue to work collaboratively with health IT voluntary consensus standards organizations to ensure that quality measures can be collected in a standardized manner.

We have worked with the Healthcare Information Technology Standards Panel (HITSP), a public private partnership whose purpose was to recommend ways to harmonize health IT interoperability standards, including the specifications of data elements used in several measure sets so that they may be collected and reported via EHRs. We are currently working with the HIT Standards Committee and the HIT Policy Committee established by HITECH to continue this standardization work. Standardization of the specifications allows software to convert clinical data of different types into a form that can be analyzed for quality measurement. We encourage collaboration among standard-setting organizations and measure developers, on the creation of standards for electronic collection of data elements for other quality measures as well, particularly those used in our quality data reporting programs.

Comment: One commenter did not support a policy that would allow CMS to have access to clinical information via an EHR for purposes of quality measure reporting because it believed that CMS would be invading the privacy of patients.

Response: We will take these concerns into consideration when developing a system to collect information from EHRs in the future.

Comment: Some commenters recommended that CMS harmonize the HOP QDRP quality measures with the meaningful use objectives under the HITECH EHR Incentive Program, as well as with other quality programs that have been authorized under the Affordable Care Act. Commenters also suggested that CMS test, adopt, and validate EHR specifications. Commenters recommended that CMS initially adopt for EHR data collection under the HOP QDRP quality measures that apply to the Emergency Department and delay adopting measures that apply to the broader outpatient setting until both hospital and CMS' technical capabilities mature. Commenters were strongly opposed to a policy under which providers would be required to submit data on the same measure multiple times under different reporting programs, but instead supported a policy under which providers could report data on a measure one time for use in multiple reporting programs.

Response: One of our important objectives is to align the quality measures used in the various existing quality data reporting programs, and to align these measures with the measures we are developing for use in new programs authorized under the Affordable Care Act. However, when considering whether particular measures can be aligned, we must take into account the needs and requirements of the various individual quality reporting programs.

We thank the commenters and will take these comments into consideration as we consider the future direction of EHR-based quality measure submission with respect to the HOP QDRP.

XVII. Files Available to the Public Via the Internet

A. Information in Addenda Related to the CY 2011 Hospital OPPS

Addenda A and B to this final rule with comment period provide various data pertaining to the CY 2011 payment for items and services under the OPPS. Addendum A, which includes a list of all APCs payable under the OPPS, and Addendum B, which includes a list of all active HCPCS codes with their CY 2011 OPPS payment status and comment indicators, are available to the public by clicking "Hospital Outpatient Regulations and Notices" on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/.*

For the convenience of the public, we also are including on the CMS Web site a table that displays the HCPCS code data in Addendum B sorted by APC assignment, identified as Addendum C.

Addendum D1 defines the payment status indicators that are used in Addenda A and B. Addendum D2 defines the comment indicators that are used in Addendum B. Addendum E lists the HCPCS codes that are only payable to hospitals as inpatient procedures and are not payable under the OPPS. Addendum L contains the out-migration wage adjustment for CY 2011.

Addendum M lists the HCPCS codes that are members of a composite APC and identifies the composite APC to which each is assigned. This addendum also identifies the status indicator for the HCPCS code and a comment indicator if there is a change in the code's status with regard to its membership in the composite APC. Each of the HCPCS codes included in Addendum M has a single procedure payment APC, listed in Addendum B, to which it is assigned when the criteria for assignment to the composite APC are not met. When the criteria for payment of the code through the composite APC are met, one unit of the composite APC payment is paid, thereby providing packaged payment for all services that are assigned to the composite APC according to the specific I/OCE logic that applies to the APC. We refer readers to the discussion of composite APCs in section II.A.2.e. of this final rule with comment period for a complete description of the composite APCs.

These addenda and other supporting OPPS data files are available on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/.*

B. Information in Addenda Related to the CY 2011 ASC Payment System

Addenda AA and BB to this final rule with comment period provide various data pertaining to the CY 2011 payment for the covered surgical procedures and covered ancillary services for which ASCs may receive separate payment. Addendum AA lists, for CY 2011, the ASC covered surgical procedures, whether the procedure is subject to multiple procedure discounting, the comment and payment indicators for each procedure, and the payment weights and rates for each procedure. Addendum BB displays, for CY 2011, the ASC covered ancillary services, the comment and payment indicators for each service and the payment weights and rates for each service. All ASC relative payment weights and payment rates for CY 2011 are a result of applying the revised ASC payment system methodology established in the final rule for the revised ASC payment system published in the **Federal Register** on August 2, 2007 (72 FR 42470 through 42548) to the CY 2011 OPPS and MPFS ratesetting information.

Addendum DD1 defines the payment indicators that are used in Addenda AA and BB. Addendum DD2 defines the comment indicators that are used in Addenda AA and BB.

Addendum EE (available only on the CMS Web site) lists the surgical procedures that are excluded from Medicare payment if furnished in ASCs. The excluded procedures listed in Addendum EE are surgical procedures that are assigned to the OPPS inpatient list, are not covered by Medicare, are reported using a CPT unlisted code, or have been determined to pose a significant safety risk to a Medicare beneficiary when performed in an ASC or for which standard medical practice dictates that the beneficiary typically requires active medical monitoring and care at midnight following the procedure.

These addenda and other supporting ASC data files are included on the CMS Web site at: *http://www.cms.gov/ASCPayment/.* The MPFS data files are located at: *http://www.cms.gov/PhysicianFeeSched/.*

The links to all of the FY 2011 IPPS wage index-related tables (that are used for the CY 2011 OPPS) that were published in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50450 through 50456) are accessible on the CMS Web site at: *http://www.cms.gov/AcuteInpatientPPS/WIFN.*

XVIII. Collection of Information Requirements

A. Legislative Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and to solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In the CY 2011 OPPS/ASC proposed rule (75 FR 46436 through 46440), we solicited public comments on each of the issues outlined above as discussed below that contained information collection requirements. We address any public comments that we received on these information collection requirements below.

B. Associated Information Collections Not Specified in Regulatory Text

In the CY 2011 OPPS/ASC proposed rule, we made reference to proposed associated information collection requirements that were not discussed in the regulation text contained in this document. The following is a discussion of those requirements.

1. Hospital Outpatient Quality Data Reporting Program (HOP QDRP)

As previously stated in section XVI. of the proposed rule and this final rule with comment period, the quality data reporting program for hospital outpatient care, known as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), has been generally modeled after the quality data reporting program for hospital inpatient services, the Hospital Inpatient Quality Reporting Program. Section 109(a) of the MIEA–TRHCA (Pub. L. 109–432) amended section 1833(t) of the Act by adding a new subsection (17) which affects the annual payment update factor applicable to OPPS payments for services furnished by hospitals in outpatient settings on or after January 1, 2009. Section 1833(t)(17)(A) of the Act states that subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Act) that fail to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act will incur a 2.0 percentage point reduction to their annual payment update factor. Section 1833(t)(17)(B) of the Act requires that hospitals submit quality data in a form and manner, and at a time, that the Secretary specifies. Section 1833(t)(17)(A)(ii) of the Act specifies that any reduction would apply only to the payment year involved and would not be taken into account in computing the applicable annual payment update factor for a subsequent payment year. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities.

We did not receive any public comments on these information collection requirements.

2. HOP QDRP Quality Measures for the CY 2012, CY 2013 and CY 2014 Payment Determinations

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68766), we retained the 7 chart-abstracted quality measures we used in CY 2009 and adopted 4 new claims-based imaging measures for the CY 2010 payment determination, bringing the total number of quality measures for which hospitals must submit data to 11 measures. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637), we required hospitals to continue to submit data on the same 11 measures for the CY 2011 payment determination. The burden associated with the aforementioned data submission requirements is currently approved under OCN: 0938–1109 and expires October 31, 2013.

We are finalizing our proposal to retain for the CY 2012 payment determination the 7 chart-abstracted quality measures and the 4 claims-based imaging measures we used for the CY 2011 payment determinations. For the CY 2012 payment determination, we are also adopting 1 structural HIT measure that tracks HOPDs' capacity to receive laboratory results electronically, and 3 claims-based imaging efficiency measures, bringing the total number of quality measures for which hospitals must submit data to 15 measures. We will calculate the claims-based measures using Medicare FFS claims data and do not require additional hospital data submissions, and we are using the same data submission requirements related to the seven data abstracted measures that we used for the CY 2011 payment determination. For the structural measure, hospitals will enter data into a Web-based collection tool during a specified collection period once annually.

For the CY 2013 payment update, we are requiring that hospitals continue to submit data for all of the quality measures that we adopted for the CY 2012 payment determination. We are also adopting 1 structural HIT measure assessing the ability to track clinical results between visits, 6 new chart-abstracted measures on the topics of HOPD care transitions and ED efficiency, as well as 1 chart-abstracted ED–AMI measure that was proposed for the CY 2012 payment determination but which we decided to finalize for the CY 2013 payment determination, bringing the total number of quality measures for which hospitals must submit data to 23 measures. We are requiring hospitals to submit data related to the 14 chart-abstracted measures. We will calculate the 7 claims-based measures using Medicare FFS claims data and do not require additional hospital data submission for these measures. For the 2 structural measures, hospitals will enter data into a Web-based collection tool during a specified collection period once annually.

For the CY 2014 payment determination, we are not adopting any new measures at this time. These measures that, as of now, will be used for the CY 2012 through CY 2014 payment determinations are listed in the table below.

HOP QDRP MEASUREMENT SET TO BE USED FOR THE CY 2012, CY 2013, AND CY 2014 PAYMENT DETERMINATIONS

OP–1: Median Time to Fibrinolysis
OP–2: Fibrinolytic Therapy Received Within 30 Minutes
OP–3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP–4: Aspirin at Arrival
OP–5: Median Time to ECG
OP–6: Timing of Antibiotic Prophylaxis
OP–7: Prophylactic Antibiotic Selection for Surgical Patients
OP–8: MRI Lumbar Spine for Low Back Pain
OP–9: Mammography Follow-up Rates
OP–10: Abdomen CT—Use of Contrast Material
OP–11: Thorax CT—Use of Contrast Material
OP–12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data *
OP–13: Cardiac Imaging for Preoperative Risk Assessment for Non Cardiac Low Risk Surgery *
OP–14: Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT) *
OP–15: Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache *
OP–16: Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with *Probable Cardiac Chest Pain*) Received Within 60 minutes of Arrival **
OP–17: Tracking Clinical Results between Visits **
OP–18: Median Time from ED Arrival to ED Departure for Discharged ED Patients **
OP–19: Transition Record with Specified Elements Received by Discharged Patients **
OP–20: Door to Diagnostic Evaluation by a Qualified Medical Professional **
OP–21: ED-Median Time to Pain Management for Long Bone Fracture **
OP–22: ED-Patient Left Before Being Seen **
OP–23: ED-Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival **

* New measure for CY 2012 payment determination.
** New measure for CY 2013 payment determination.

As part of the data submission process pertaining to the quality measures we are finalizing for the CY 2012 payment determination, hospitals must complete and submit a notice of participation form for the HOP QDRP. By submitting this document, hospitals agree that they will allow CMS to publicly report the quality measures as required by the HOP QDRP.

For the CY 2012 payment determination, the burden associated with this requirement is the time and effort associated with completing the notice of participation form as well as collecting and submitting the data on the required quality measures. We estimate that there will be approximately 3,200 respondents per year. For hospitals to collect and submit the information on the required measures, we estimate it will take 35 minutes per sampled case. We estimate there will be a total of 930,000 cases per year, approximately 290 cases per year per respondent. The estimated annual burden associated with the

aforementioned submission requirements for the chart-abstracted data is 542,500 hours (930,000 cases per year × 0.583 hours/case). For the structural measure, we estimate that each participating hospital will spend 10 minutes per year to collect and submit the required data, making the estimated annual burden associated with this measure 533 hours (3,200 hospitals × 0.167 hours per hospital).

For the CY 2013 payment determination, the burden associated with this requirement is the time and effort associated with completing the notice of participation form as well as collecting and submitting the data on the required quality measures. We estimate that there will be approximately 3,200 respondents per year. For hospitals to collect and submit the information on the required measures, we estimate it will take 35 minutes per sampled case. We estimate there will be a total of 1,860,000 cases per year, approximately 580 cases per year per respondent. The estimated annual burden associated with the aforementioned submission requirements for the chart-abstracted data is 1,084,380 hours (1,860,000 cases per year × 0.583 hours/case). For the structural measures, we estimate that each participating hospital will spend 20 minutes per year to collect and submit the required data, making the estimated annual burden associated with this measure 1,066 hours (3,200 hospitals × 0.334 hours per hospital).

In the proposed rule, we invited public comment on the burden associated with these information collection requirements. We did not receive any public comments on these information collection requirements.

3. HOP QDRP Validation Requirements

In addition to finalizing requirements related to the submission of quality data, in this final rule with comment period we are finalizing requirements related to data validation for CY 2012. Similar to our proposed and final policy for the FY 2012 Hospital Inpatient Quality Reporting Program (75 FR 23991 through 23993 and 50225 through 50227), we will validate data from 800 randomly selected hospitals each year under the HOP QDRP, beginning with the CY 2012 payment determination. We note that, because the 800 hospitals would be selected randomly, every HOP QDRP-participating hospital would be eligible each year for validation selection. For each selected hospital, we would randomly select up to 48 patient episodes of care per year (12 per quarter) for validation purposes from the total number of cases that the hospital successfully submitted to the OPPS Clinical Warehouse during the applicable time period. However, if a selected hospital submitted less than 12 cases in one or more quarters, only those cases available would be validated.

The burden associated with the CY 2012 requirement is the time and effort necessary to submit validation data to a CMS contractor. We estimate that it will take each of the 800 sampled hospitals approximately 12 hours to comply with these data submission requirements. To comply with the requirements, we estimate each hospital must submit 48 cases for the affected year for review. We are requiring that 800 hospitals comply with these requirements per year, which will result in a total of 38,400 charts being submitted by the sampled hospitals. The estimated annual burden associated with the data validation process for CY 2012 and subsequent years is 9,600 hours. While these requirements are subject to the PRA, they are currently approved under OCN: 0938–1109 and expire October 31, 2013.

In the proposed rule, we invited public comment on the burden associated with these information collection requirements.

Comment: One commenter stated that the proposed validation requirements are reasonable and would be acceptable to providers if they were the only Federal data submission requirements. The commenter stated its concern that the record requests for validation would supplement those already established as part of Federal integrity audit processes (for example, RAC, Medicaid Integrity, ZPIC, and MAC) and facilities would receive multiple requests from each contracted entity, significantly increasing a hospital provider's labor investment and costs. The commenter urged CMS to review the validation process with respect to other data requirements rather than seeing it as a single request, and to consider the operational impact that receiving multiple audit entity requests will have on any single provider.

Response: We understand the commenter's concern regarding multiple Federal medical record requests. For HOP QDRP validation, we have worked to limit overall burden by reducing the number of hospitals participating annually in validation through our random sampling of hospitals. In addition, hospitals will be reimbursed for photocopying and mailing costs as they are under the Hospital Inpatient Quality Reporting Program, thus reducing the burden in submitting medical record documentation for HOP QDRP validation purposes. We agree that efforts should be made to keep record requests for validation purposes at the minimum necessary to ensure the accuracy of submitted data and will consider ways to do so in future rulemaking.

4. HOP QDRP Reconsideration and Appeals Procedures

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68779), we adopted a mandatory reconsideration process that applied to the CY 2010 payment decisions. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60654 through 60655), we continued this process for the CY 2011 payment update. In the CY 2011 OPPS/ASC proposed rule (75 FR 46381 through 46382), we proposed to continue this process for the CY 2012 payment update with some modifications. We proposed to eliminate a requirement that the reconsideration request form be signed by the hospital CEO to facilitate electronic submission of the form and reduce hospital burden. Under this proposed process, the hospitals would be required to meet all of the requirements specified in section XVI.E. of the CY 2011 OPPS/ASC proposed rule. We are finalizing this proposal in this final rule with comment period. While there is burden associated with filing a reconsideration request, section 5 CFR 1320.4 of the Paperwork Reduction Act of 1995 regulations excludes collection activities during the conduct of administrative actions such as re-determinations, reconsiderations, and/or appeals.

We did not receive any public comments on these information collection requirements.

5. Additional Topics

In addition to seeking OMB approval for the information collection requirements associated with the HOP QDRP and the data validation processes, we sought public comment on several issues that may ultimately affect the burden associated with the HOP QDRP and associated data validation processes. Specifically, in the proposed rule we proposed to adopt quality measures for the CY 2012 through CY 2014 payment determinations, as well as sought comments on other possible quality measures under consideration for adoption into the HOP QDRP. We also solicited public comments on the use of registries to comply with the HOP QDRP submission requirements, the use of EHRs as a data submission tool, the use of a standardized process for the retirement of HOP QDRP quality

measures, the continued use of an extraordinary circumstance extension or waiver for reporting quality data, and additional data validation conditions that we are considering adopting beginning with the CY 2013 payment determination.

Comments and responses for the issues of registries, EHRs, quality measure retirements, the continued use of an extraordinary circumstance extension or waiver for reporting quality data, and additional data validation conditions are addressed in section XVI. of this final rule with comment period.

XIX. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this final rule with comment period, and, when we proceed with a subsequent document(s), we will respond to those comments in the preamble to that document(s).

XX. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this final rule with comment period as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

1. Executive Order 12866

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules that have economically significant effects ($100 million or more in any 1 year) or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal government or communities (58 FR 51741).

We estimate that the effects of the OPPS provisions that will be implemented by this final rule with comment period will result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in this final rule with comment period as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2011 compared to CY 2010 to be approximately $3.2 billion. Because this final rule with comment period for the OPPS is "economically significant" as measured by the $100 million threshold and also a major rule under the Congressional Review Act, we have prepared a regulatory impact analysis that, to the best of our ability, presents the costs and benefits of this rulemaking. Table 66 of this final rule with comment period displays the redistributional impact of the CY 2011 changes on OPPS payment to various groups of hospitals.

We estimate that the effects of the ASC provisions that will be implemented by this final rule with comment period for the ASC payment system will result in expenditures exceeding $100 million in any one year. We estimate the total increase (from changes in this final rule with comment period as well as enrollment, utilization, and case-mix changes) in expenditures under the ASC payment system for CY 2011 compared to CY 2010 to be approximately $230 million. Because this final rule with comment period for the ASC payment system is "economically significant" as measured by the $100 million threshold and also a major rule under the Congressional Review Act, we have prepared a regulatory impact analysis of changes to the ASC payment system that, to the best of our ability, presents the costs and benefits of this rulemaking. Table 68 and Table 69 of this final rule with comment period display the redistributional impact of the CY 2011 changes on ASC payment, grouped by specialty area and then grouped by procedures with the greatest ASC expenditures, respectively.

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Many hospitals, other providers, ASCs, and other suppliers are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (hospitals having revenues of $34.5 million or less in any 1 year and ASCs having revenues of $10 million or less in any 1 year). (For details on the latest standards for health care providers, we refer readers the SBA's Web site at: *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series).)

For purposes of the RFA, we have determined that many hospitals and most ASCs will be considered small entities according to the SBA size standards. Individuals and States are not included in the definition of a small entity. Therefore, the Secretary has determined that this final rule with comment period will have a significant impact on a substantial number of small entities. Because we acknowledge that many of the affected entities are small entities, the analyses presented throughout this final rule with comment period constitute our regulatory flexibility analysis. Therefore, in the CY 2011 OPPS/ASC proposed rule (75 FR 46441), we solicited public comments on our estimates and analyses of the impact of the proposed rule on those small entities.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban areas. Thus, for OPPS purposes, we continue to classify these hospitals as urban hospitals. We believe that the changes to the OPPS in this final rule with comment period will affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Also, the changes to the ASC payment system in this final rule with comment period will affect rural ASCs. Therefore, the Secretary has determined that this final rule with comment period will have a significant impact on the operations of a substantial number of small rural hospitals.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA)

also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $135 million. This final rule with comment period will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined the OPPS and ASC provisions included in this final rule with comment period in accordance with Executive Order 13132, Federalism, and have determined that they will not have a substantial direct effect on State, local or tribal governments, preempt State law, or otherwise have a Federalism implication. As reflected in Table 66 below, we estimate that OPPS payments to governmental hospitals (including State and local governmental hospitals) will increase by 2.9 percent under this final rule with comment period. While we do not know the number of ASCs with government ownership, we anticipate that it is small. We believe that the provisions related to payments to ASCs in CY 2011 will not affect payments to any ASCs owned by government entities.

The following analysis, in conjunction with the remainder of this document, demonstrates that this final rule with comment period is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act.

This final rule with comment period will affect payments to a substantial number of small rural hospitals and a small number of rural ASCs, as well as other classes of hospitals and ASCs, and some effects may be significant.

B. Effects of OPPS Changes in This Final Rule With Comment Period

We are making several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We also are required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments, including pass-through payments and outlier payments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this final rule with comment period, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2011, as we discuss in sections II.B. and II.C., respectively, of this final rule with comment period. We discuss our implementation of section 10324 of the Affordable Care Act, as amended by HCERA, authorizing a wage index of 1.00 for certain frontier states. We also are revising the relative APC payment weights using claims data for services furnished from January 1, 2009, through December 31, 2009, and updated cost report information. We are continuing the current payment adjustment for rural SCHs, including EACHs. Finally, we list the 18 drugs and biologicals in Table 27 of this final rule with comment period that we are removing from pass-through payment status for CY 2011.

Under this final rule with comment period, we estimate that the update change to the conversion factor and other adjustments (but not including the effects of outlier payments, pass through estimates, the expiration of section 508 wages on September 30, 2010, and the application of the frontier wage adjustment for CY 2011) as provided by the statute, will increase total OPPS payments by 2.3 percent in CY 2011. The changes to the APC weights, the changes to the wage indices, and the continuation of a payment adjustment for rural SCHs, including EACHs, will not increase OPPS payments because these changes to the OPPS are budget neutral. However, these updates do change the distribution of payments within the budget neutral system as shown in Table 66 below and described in more detail in this section. We also estimate that the total change in payments between CY 2010 and CY 2011, considering all payments, including changes in estimated total outlier payments, pass through payments, the expiration of additional money for specified section 508 reclassification and special exception wages indices, and the application of the frontier adjustment outside of budget neutrality, in addition to the application of the hospital market basket will increase total OPPS payments by 2.5 percent.

1. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options are discussed throughout this final rule with comment period. Some of the major issues discussed in this final rule with comment period and the options considered are discussed below.

a. Alternatives Considered for the Extension of Waiver of Deductible to Services Furnished in Connection With or in Relation to a Colorectal Screening Test That Becomes Diagnostic

Section 4104(c)(2) of the Affordable Care Act waives the deductible with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test. We are finalizing our proposal for CY 2011 that the deductible be waived for all surgical services furnished on the same date as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test. As discussed in detail in XII.B.3. of this final rule with comment period, we are implementing this provision by creating a HCPCS modifier that hospitals will append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service. The claims processing system will respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance or copayment will continue to apply to the diagnostic test and other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

We considered three alternatives for the extension of wavier of deductible to services furnished in connection with or in relation to a colorectal screening test that becomes diagnostic for CY 2011. The first alternative we considered was to define a limited set of colonoscopy codes to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy, screening flexible sigmoidoscopy, or barium enema. We did not choose this alternative because it is virtually impossible to create a valid and complete list of appropriate procedures to handle all situations, due to the range of problems that could be identified and complications that could occur with any invasive procedures.

Furthermore, we believe this alternative would be complex to implement. Although this alternative narrows the potential for hospitals to abuse the waiver of the deductible by applying it to unrelated services, we believe the potential for abuse of the waiver of the deductible to be minimal. The Part B deductible is a fixed amount that the beneficiary pays before Medicare begins to pay and typically will be met after receiving one to two services.

The second alternative we considered was to define a broader, but still limited set of codes (for example, selected surgical services) to which the waiver would apply when performed on the same date as a procedure that began as a screening colonoscopy, screening flexible sigmoidoscopy, or barium enema. Although this alternative would encompass a broader set of codes, we believe it is virtually impossible to create a valid and complete list of appropriate procedures to handle all situations, due to the range of problems that could be identified and complications that could occur with any invasive procedures. While we acknowledge that this alternative would narrow the potential for abuse of the waiver of the deductible, we believe the potential for abuse is minimal and that this alternative also would be complex to implement. For these reasons we did not choose to define a broader set of limited codes to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy, screening flexible sigmoidoscopy, or barium enema.

The third alternative we considered, and the one we are adopting for CY 2011, is to apply the waiver to any surgical procedure that is reported with the same date as a screening colonoscopy, flexible sigmoidoscopy, or barium enema and that providers report is "in connection with or as a result of" the procedure that began as a screening test. As we discuss in detail in section XII.B.3. of this final rule with comment period, we have created HCPCS modifier "PT" that providers will append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service. We chose this alternative because we believe it provides the greatest ease of public understanding and provider application. We believe that this alternative is appropriate because we believe that it will be very rare for an unrelated surgery to occur on the same date as one of these scheduled screening tests. Moreover, we believe that the risk of improper expenditures will be very small under this policy because it is the deductible, and not the coinsurance, that is waived for the related procedures other than the screening tests. As noted above, the Part B deductible is a fixed amount that the beneficiary pays before Medicare begins to pay and typically will be met after receiving one to two services.

b. Alternatives Considered for Payment of the Acquisition and Pharmacy Overhead Costs of Drugs and Biologicals That Do Not Have Pass-Through Status

We are finalizing our proposal that, for CY 2011, the OPPS will make payment for separately payable drugs and biologicals under the methodology that we proposed, which, for CY 2011, results in payment for separately paid drugs and biologicals at ASP+5 percent. This payment will continue to represent combined payment for both the acquisition and pharmacy overhead costs of separately payable drugs and biologicals. As discussed in detail in section V.B.3. of this final rule with comment period, we believe that approximately $150 million of the estimated $457 million in pharmacy overhead cost currently attributed to coded packaged drugs with an ASP and $50 million of the overhead cost currently attributed to uncoded packaged drugs without an ASP should, instead, be attributed to separately payable drugs and biologicals to provide an adjustment for the pharmacy overhead costs of these separately payable products. As a result, we also are reducing the cost of packaged drugs and biologicals that is included in the payment for procedural APCs to offset the $200 million adjustment to payment for separately payable drugs and biologicals. We are finalizing our proposal that any redistribution of pharmacy overhead cost that may arise from CY 2011 final rule claims data will occur only from some drugs and biologicals to other drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals under the OPPS.

We considered three alternatives for payment of the acquisition and pharmacy overhead costs of drugs and biologicals that do not have pass-through status for CY 2011. The first alternative we considered was to continue our standard policy of comparing the estimated aggregate cost of separately payable drugs and biologicals in our claims data to the estimated aggregate ASP dollars for separately payable drugs and biologicals, using the ASP as a proxy for average acquisition cost, to calculate the estimated percent of ASP that will serve as the best proxy for the combined acquisition and pharmacy overhead costs of separately payable drugs and biologicals (70 FR 68642). Under this standard methodology, using July 2010 ASP information and costs derived from CY 2009 OPPS final rule claims data, we estimated the combined acquisition and overhead costs of separately payable drugs and biologicals to be ASP minus 1 percent. As discussed in section V.B.3. of this final rule with comment period, we also determined that the combined acquisition and overhead costs of packaged drugs are 296 percent of ASP. We did not choose this alternative because we believe that this analysis indicates that our standard drug payment methodology has the potential to "compress" the calculated costs of separately payable drugs and biologicals to some degree. Further, we recognize that the attribution of pharmacy overhead costs to packaged or separately payable drugs and biologicals through our standard drug payment methodology of a combined payment for acquisition and pharmacy overhead costs depends, in part, on the treatment of all drugs and biologicals each year under our annual drug packaging threshold. Changes to the packaging threshold may result in changes to payment for the overhead cost of drugs and biologicals that do not reflect actual changes in hospital pharmacy overhead cost for those products.

The second alternative we considered was to adopt the APC Panel's February 2010 recommendation to redistribute a larger portion of the overhead cost from packaged drugs to separately payable drugs for payment of drugs and biologicals that do not have pass-through status. We did not choose this alternative because, as we discussed in V.B.3. of this final rule with comment period, we are not confident that we know the amount of overhead cost available for redistribution in the uncoded packaged drugs and, therefore, do not know if it is appropriate to redistribute more payment from uncoded packaged drugs to separately paid drugs. Presenters at the February 2010 APC Panel meeting provided analyses suggesting that the uncoded packaged drug cost contain exactly the same drugs as those in the coded packaged drug cost, leading to a recommendation that we could assume the same proportional amount of overhead cost appears in the uncoded packaged drug cost as observed in the coded packaged drug cost in order to increase the amount of "overhead" drug

cost available for redistribution from uncoded packaged drugs to separately payable drugs. Public comments on the proposed rule make comparable comments, and presenters at the August 2010 APC Panel meeting reiterated their recommended assumption of comparable overhead amounts. However, we do not believe we should assume that the costs reported under uncoded pharmacy revenue code lines are for the same drugs and biologicals, with the same ASPs, and overhead costs as the costs of packaged drugs and biologicals reported with a HCPCS code. For these reasons, we are not accepting the APC Panel's recommendation to redistribute a larger portion of overhead costs from packaged drugs to separately payable drugs for CY 2011.

The third alternative we considered and the one we selected for CY 2011 is to continue our CY 2010 redistribution methodology and redistribute $200 million in overhead costs from packaged coded and uncoded drugs to separately payable drugs which will result in a payment for non-pass-through separately payable drugs and biologicals at ASP+5 percent, which will continue to represent a combined payment for both the acquisition costs of separately payable drugs and the pharmacy overhead costs applicable to these products. We also are reducing the cost of packaged drugs that is included in the payment for procedural APCs to offset the $200 million adjustment to payment for separately payable drugs and biologicals, resulting in payment for packaged drugs and biologicals of ASP+198 percent. We chose this alternative because we believe that it provides the most appropriate redistribution of pharmacy overhead costs associated with drugs and biologicals, based on the analyses discussed in section V.B.3. of this final rule with comment period, and is the alternative that is most consistent with the principles of a prospective payment system.

c. Alternatives Considered for the Physician Supervision of Hospital Outpatient Services

Our proposed revision to our requirement for direct supervision of therapeutic services provided to hospital and CAH outpatients attempted to address industry concerns brought to our attention since we issued our CY 2010 final rule with comment period. The primary issue raised by CAHs, rural hospitals and other small hospitals following CY 2010 rulemaking was difficulty in staffing their facilities to meet our requirement for direct supervision of all outpatient therapeutic services, but especially services that involve a significant amount of monitoring by auxiliary staff, that may extend past regular business hours, and that typically are lower clinical complexity and risk. Our proposal to establish a limited set of "non-surgical extended duration therapeutic services" (extended duration services) was designed to address these issues. For these services, we proposed to require only a minimum of direct supervision during an initial period, followed by general supervision for the remainder of the service. Public commenters appreciated our attempt to offer flexibility through our proposal for non-surgical extended duration services, but made several additional requests. First, they note that direct supervision should require the supervising physician or nonphysician practitioner be available, but not specify a physical location. Commenters also requested that CMS adopt general supervision for all therapeutic services. They noted that there are other types of outpatient services that they believe qualify for general supervision, and they made extensive requests for an independent assessment of the clinically appropriate supervision level for any given outpatient service. In order to address these concerns while maintaining an adequate level of safety and quality of care, we are finalizing a supervision policy with the following four components:

1. We are maintaining our default requirement for direct supervision of all outpatient therapeutic services. However, we are revising our definition of direct supervision of both outpatient therapeutic and diagnostic services (except for diagnostic services provided under arrangement in non-hospital locations) to require only "immediate availability," meaning physically immediately available, without specifying a particular physical boundary.

2. Through rulemaking for CY 2012, we will develop a process to consider industry requests for alternative service-specific supervision levels that will include an independent technical advisory committee, potentially the APC Panel.

3. In the interim, we are extending for one year (through CY 2011) our notice of non-enforcement of the current policy for direct supervision of all outpatient therapeutic services furnished in CAHs (*http://www.cms.gov/HospitalOutpatientPPS/Downloads/WebNotice.pdf*). Because CAHs and small rural hospitals paid under the OPPS face comparable staffing challenges, we are extending this provision to hospitals geographically located in a rural area or designated to be located in a rural area for their wage index that have 100 or fewer beds.

4. Finally, for CY 2011, we are finalizing our proposal to establish a limited set of nonsurgical extended duration services for which we would allow direct supervision during the initiation of the service followed by general supervision for the remainder of service at the discretion of the supervising physician or nonphysician practitioner. The list of nonsurgical extended duration therapeutic services subject to this policy for CY 2011 appears in Table 48A of this final rule with comment period.

We considered two alternatives that we believed may have increased flexibility while sustaining our payment requirement for direct supervision of therapeutic hospital outpatient services provided incident to physicians' services. First, we considered offering hospitals the flexibility of broadening the list of extended duration services to include more complex and potentially acute services like chemotherapy administration and blood transfusions, which some stakeholders also maintain do not require direct supervision. Because we were concerned that these services had a higher probability of needing a physician or nonphysician practitioner to furnish assistance and direction through provision of the service, we had reasoned that we could require hospitals to create internal guidelines specifying a supervision level and protocols for staffing that supervision level for every extended duration service, including chemotherapy administration and blood transfusions. We considered minimum requirements for these internal supervision guidelines, including annual review and approval by a governing committee, periodic internal evaluation, and the ability to make these guidelines available to auditors if requested. Further, auditors would review those guidelines if a quality or patient safety event were to occur. Fundamentally, we did not choose this policy because, while many commenters liked this option for the flexibility that it offered, it did not address commenters fundamental concern that our uniform requirement for direct supervision as a condition of payment did not consider the relative risk for needing a supervising physician or nonphysician practitioner's physical presence against the cost of providing direct supervision. Because commenters disagreed about the appropriate level of supervision for individual services, such as chemotherapy, and because we continue

to believe supervision is a key component of the service Medicare purchases for its beneficiaries, we believe that an independent entity, whether the APC Panel or other technical committee, should evaluate services for the appropriate supervision level, potentially something other than direct supervision, to support provision of a safe, quality service. We also did not choose this alternative because some commenters did believe the policy would be burdensome to implement and maintain. Finally, we rejected this alternative because a variable standard of supervision across hospitals could be administratively difficult for us to audit and evaluate.

Second, we considered whether to exclude CAHs from the requirements for direct supervision of therapeutic services. We considered limiting CAHs to their CoPs, which in effect only require them to operate under general supervision. We also considered extending the notice of nonenforcement while we further develop policies. As discussed above, we believe there are strong grounds for applying the same supervision requirements to CAHs as to all other hospitals. One of these grounds is that hospital outpatient services are furnished "incident to" physicians' services, and we believe that the incident to rules apply equally to critical access and other types of hospitals. We continue to believe that Medicare should purchase the same basic level of quality and safe outpatient care for all beneficiaries, whether from a CAH, a small rural hospital, or other hospitals. Moreover, having reviewed public comments, we do not believe it is safe to permit general supervision of all hospital outpatient therapeutic services. At the same time, we acknowledge that in order to purchase the same outpatient care from CAHs as other hospitals, we need to have a national discussion about what constitutes the appropriate supervision for a given service. Therefore, we decided to extend the notice of nonenforcement for CAHs, as well as adding in small rural hospitals, while we propose and finalize a process for evaluating service-specific supervision levels.

We believe that the policies in this final rule will address industry concerns while maintaining an adequate level of safety and quality of care in the hospital outpatient services that Medicare purchases.

2. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the CY 2011 policy changes on various hospital groups. We post on the CMS Web site our hospital-specific estimated payments for CY 2011 with the other supporting documentation for this final rule with comment period. To view the hospital-specific estimates, we refer readers to the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/.* Select "regulations and notices" from the left side of the page and then select "CMS–1504–FC" from the list of regulations and notices. The hospital-specific file layout and the hospital-specific file are listed with the other supporting documentation for this final rule with comment period. We show hospital-specific data only for hospitals whose claims were used for modeling the impacts shown in Table 66 below. We do not show hospital-specific impacts for hospitals whose claims we were unable to use. We refer readers to section II.A.2. of this final rule with comment period for a discussion of the hospitals whose claims we do not use for ratesetting and impact purposes.

We estimate the effects of the individual policy changes by estimating payments per service, while holding all other payment policies constant. We use the best data available, but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters. As we have done in previous rules, in the CY 2011 OPPS/ASC proposed rule (75 FR 46445), we solicited public comment and information about the anticipated effects of our changes on providers and our methodology for estimating them.

We received many public comments on the proposed changes to payment policies and to proposed payment rates for the CY 2011 OPPS. We have summarized these public comments and provided our responses to them in other sections of this final rule with comment period as part of our discussions of the specific topics to which the comments pertained. We did not receive any public comments on our methodology for estimating the anticipated effects of our proposed changes on providers or other parties. For the reasons set forth in the proposed rule (75 FR 46444), we are finalizing our proposed methodology for estimating the anticipated effects of our proposed changes on providers or other parties.

3. Estimated Effects of This Final Rule with Comment Period on Hospitals

Table 66 below shows the estimated impact of this final rule with comment period on hospitals. Historically, the first line of the impact table, which estimates the change in payments to all hospitals, has always included cancer and children's hospitals, which are held harmless to their pre-BBA payment-to-cost ratio. As discussed in section II.F. of this final rule with comment period, we are not finalizing our proposal to extend an adjustment to certain cancer hospitals under section 3138 of the Affordable Care Act. Because these hospitals will continue to receive hold harmless payments, per our standard policy, we have excluded them from this impact table. We also include CMHCs in the first line that includes all providers because we include CMHCs in our weight scalar estimate.

We present separate impacts for CMHCs in Table 66 because CMHCs are paid only for partial hospitalization services and CMHCs are a different provider type from hospitals. For CY 2010, CMHCs and hospitals were paid under two APCs for services under the OPPS: APC 0172 (Level 1 Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). For CY 2011, we are paying CMHCs under APC 0172 (Level I Partial Hospitalization (3 services) for CMHCs) and APC 0173 (Level II Partial Hospitalization (4 or more services) for CMHCs), and we are paying hospitals for partial hospitalization services under APC 0175 (Level I Partial Hospitalization (3 services) for Hospital-based PHPs) and APC 0176 (Level II Partial Hospitalization (4 or more services) for Hospital-based PHPs). We display the impact on CMHCs of this policy change below and we discuss the impact on CMHCs in section XX.B.4. of this final rule with comment period.

The estimated increase in the total payments made under the OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service mix. The increase to the conversion factor is reduced by 0.25 percentage point as required by section 3401(i) of the Affordable Care Act and as amended by section 10319(g) of such Act and further amended by section 1105(e) of such Act. Section 3137 of the Affordable Care Act, as amended by the HCERA, extended additional payment to section 508 reclassification hospitals and special exception hospital wages outside budget neutrality through September 30, 2010. The amounts attributable to these reclassifications are incorporated into the CY 2010 estimates in Table 66. Section 10324 of the Affordable Care Act, as amended by HCERA, further authorized additional

expenditures outside budget neutrality for hospitals in certain frontier States to have a wage index of 1.00. The amounts attributable to this frontier State wage index adjustment are incorporated into the CY 2011 estimates in Table 66.

Table 66 shows the estimated redistribution of hospital and CMHC payments among providers as a result of APC reconfiguration and recalibration; wage indices and the rural adjustment; the combined impact of the APC recalibration, wage and rural adjustment effects, and the market basket update to the conversion factor; the frontier State wage index adjustment; and, finally, estimated redistribution considering all payments for CY 2011 relative to all payments for CY 2010, including the impact of changes in estimated outlier payments, expiring section 508 wage indices, and changes to the pass-through payment estimate. We did not model an explicit budget neutrality adjustment for the rural adjustment for SCHs because we are not making any changes to the policy for CY 2011. Because the updates to the conversion factor, including the update of the market basket, less the market basket reduction authorized under the Affordable Care Act, and the subtraction of additional money dedicated to pass-through payment for CY 2011, are applied uniformly across services, observed redistributions of payments in the impact table for hospitals largely depend on the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services will change), and the impact of the wage index changes on the hospital. However, total payments made under this system and the extent to which this final rule with comment period will redistribute money during implementation also will depend on changes in volume, practice patterns, and the mix of services billed between CY 2010 and CY 2011 by various groups of hospitals, which CMS cannot forecast.

Overall, the OPPS rates for CY 2011 will have a positive effect for providers paid under the OPPS, resulting in a 2.5 percent estimated increase in Medicare payments. Removing cancer and children's hospitals because their payments are held harmless to the pre-OPPS ratio between payment and cost and CMHCs suggests that these changes will result in a 2.8 percent estimated increase in Medicare payments to all other hospitals.

To illustrate the impact of the final CY 2011 changes, our analysis begins with a baseline simulation model that uses the final CY 2010 weights, the FY 2010 final IPPS wage indices that include reclassifications, and the final CY 2010 conversion factor. Column 2 in Table 66 shows the independent effect of the changes resulting from the reclassification of services among APC groups and the recalibration of APC weights, based on 12 months of CY 2009 OPPS hospital claims data and the most recent cost report data. We modeled the effect of the APC recalibration changes for CY 2011 by varying only the weights (the final CY 2010 weights versus the final CY 2011 weights calculated using the service mix and volume in the CY 2009 claims used for this final rule with comment period) and calculating the percent difference in weight. Column 2 also reflects the effect of the changes resulting from the APC reclassification and recalibration changes and any changes in multiple procedure discount patterns or conditional packaging that occur as a result of the changes in the relative magnitude of payment weights.

Column 3 reflects the independent effects of the updated wage indices, including the application of budget neutrality for the rural floor policy on a nationwide basis. This column excludes the effects of the frontier wage index adjustment, which is not budget neutral and is shown in column 5. We did not model a budget neutrality adjustment for the rural adjustment for SCHs because we are making no changes to the policy for CY 2011. We modeled the independent effect of updating the wage indices by varying only the wage indices, holding APC relative weights, service mix, and the rural adjustment constant and using the CY 2011 scaled weights and a CY 2010 conversion factor that included a budget neutrality adjustment for the effect of changing the wage indices between CY 2010 and CY 2011.

Column 4 demonstrates the combined "budget neutral" impact of APC recalibration (that is, Column 2), the wage index update (that is, Column 3), as well as the impact of updating the conversion factor with the adjusted OPD fee schedule increase (also commonly known as the market basket update, in this case, the 2.6 percent hospital market basket update less the 0.25 percentage point reduction required by the Affordable Care Act). We modeled the independent effect of the budget neutrality adjustments and the adjusted OPD fee schedule increase by using the weights and wage indices for each year, and using a CY 2010 conversion factor that included the adjusted OPD fee schedule increase and a budget neutrality adjustment for differences in wage indices.

Column 5 demonstrates the impact of the budget neutral adjustments and the OPD fee schedule increase reflected in Column 4 combined with the non-budget neutral frontier State wage index adjustment, discussed in section II.C.1. of this final rule with comment period.

Finally, Column 6 depicts the full impact of the CY 2011 policies on each hospital group by including the effect of all the changes for CY 2011 (including the APC reconfiguration and recalibration shown in Column 2) and comparing them to all estimated payments in CY 2010 (these CY 2010 estimated payments include the payments resulting from the non-budget neutral increases to wage indices under section 508 of Public Law 108–173 as extended by Public Law 111–148 through September 30, 2010). Column 6 shows the combined budget neutral effects of Columns 2 through 4, plus the impact of the frontier State wage index adjustment; the change to the fixed-dollar outlier threshold from $2,175 to $2,025 as discussed in section II.G. of this final rule with comment period; the expiration of section 508 reclassifications; the change in the HOP QDRP payment reduction for the small number of hospitals in our impact model that failed to meet the reporting requirements (see section XVI.D. of this final rule with comment period); and the impact of increasing the estimate of the percentage of total OPPS payments dedicated to transitional pass-through payments. Of the 90 hospitals that failed to meet the HOP QDRP reporting requirements for the full CY 2010 update (and assumed, for modeling purposes, to be the same number for CY 2011), we included 11 hospitals in our model because they had both CY 2009 claims data and recent cost report data. We estimate that the cumulative effect of all changes for CY 2011 will increase payments to all providers by 2.5 percent for CY 2011. We modeled the independent effect of all changes in Column 6 using the final weights for CY 2010 and the final weights for CY 2011. We used the final conversion factor for CY 2010 of $67.241, which was announced in the notice describing implementation of the Affordable Care Act provisions (75 FR 45769) and the CY 2011 conversion factor of $68.876 discussed in section II.B. of this final rule with comment period.

Column 6 also contains simulated outlier payments for each year. We used the charge inflation factor used in the FY 2011 IPPS/LTCH PPS final rule of 4.83 percent (1.0483) to increase individual costs on the CY 2009 claims, and we used the most recent overall CCR in the July 2010 Outpatient Provider-Specific File (OPSF). Using the CY 2009 claims and a 4.83 percent

charge inflation factor, we currently estimate that outlier payments for CY 2010, using a multiple threshold of 1.75 and a fixed-dollar threshold of $2,175, will be approximately 0.85 percent of total payments. Outlier payments of 0.85 percent are incorporated in the CY 2010 comparison in Column 6. We used the same set of claims and a charge inflation factor of 9.88 percent (1.0988) and the CCRs in the July 2010 OPSF, with an adjustment of 0.9910, to reflect relative changes in cost and charge inflation between CY 2009 and CY 2011, to model the CY 2011 outliers at 1.0 percent of estimated total payments using a multiple threshold of 1.75 and a fixed-dollar threshold of $2,025.

Column 1: Total Number of Hospitals

The first line in Column 1 in Table 66 shows the total number of providers (4,185), including designated cancer and children's hospitals and CMHCs for which we were able to use CY 2009 hospital outpatient claims to model CY 2010 and CY 2011 payments, by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2010 or CY 2011 payment and entities that are not paid under the OPPS. The latter entities include CAHs, all-inclusive hospitals, and hospitals located in Guam, the U.S. Virgin Islands, Northern Mariana Islands, American Samoa, and the State of Maryland. This process is discussed in greater detail in section II.A. of this final rule with comment period. At this time, we are unable to calculate a disproportionate share (DSH) variable for hospitals not participating in the IPPS. Hospitals for which we do not have a DSH variable are grouped separately and generally include freestanding psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals. We show the total number (3,906) of OPPS hospitals, excluding the hold-harmless cancer and children's hospitals and CMHCs, on the second line of the table. We excluded cancer and children's hospitals because section 1833(t)(7)(D) of the Act permanently holds harmless cancer hospitals and children's hospitals to their proportional payment relative to reasonable cost prior to payment under the OPPS and, therefore, we removed them from our impact analyses. We show the isolated impact on 217 CMHCs at the bottom of the impact table and discuss that impact separately below.

Column 2: APC Changes Due to Reassignment and Recalibration

This column shows the combined effects of the reconfiguration, recalibration, and other policies (such as setting payment for separately payable drugs and biologicals at ASP+5 percent with an accompanying reduction in the amount of cost associated with packaged drugs and biologicals and changes in payment for PHP services). Overall, we estimate that changes in APC reassignment and recalibration across all services paid under the OPPS will increase payments to urban hospitals by 0.3 percent. We estimate that both large and other urban hospitals will see an increase of 0.3 percent, all attributable to recalibration. We estimate that urban hospitals billing fewer than 5,000 lines for OPPS services will experience an increases of 2.2, while urban hospitals billing 5,000 or more lines for OPPS services will see increases of 0.1 to 0.7 percent.

Overall, we estimate that rural hospitals will experience no change as a result of changes to the APC structure. We estimate that rural hospitals with fewer than 101 beds will experience decreases of 0.1 to 0.5 percent as a result of APC recalibration and that rural hospitals with 101 beds or more will experience increases up to 0.4 percent as a result of APC recalibration. We estimate that rural hospitals that report fewer than 43,000 lines for OPPS services will experience decreases of 1.2 to 0.4 percent, while rural hospitals that report 43,000 or more lines for OPPS services will see an increase of 0.1 percent in payment as a result of APC recalibration.

Among teaching hospitals, we estimate that the impact resulting from APC recalibration will include an increase of 0.4 percent for major teaching hospitals and an increase of 0.3 for minor teaching hospitals.

Classifying hospitals by type of ownership suggests that voluntary, proprietary and governmental hospitals will see an estimated increase of 0.3 percent as a result of APC recalibration.

Finally, we estimate that hospitals for which DSH payments are not available will experience a decrease of 0.7 to 0.4 percent. We estimate that most other classes of hospitals will experience modest increases from CY 2010 to CY 2011 resulting from APC recalibration.

Column 3: New Wage Indices and the Effect of the Rural Adjustment

This column estimates the impact of applying the final FY 2011 IPPS wage indices for the CY 2011 OPPS without the influence of the frontier State wage index adjustment or the expiration of the section 508 wage index adjustment, which are not budget neutral. The frontier State wage index adjustment is reflected in the combined impact shown in columns 5 and 6. The expiring section 508 adjustment is reflected in column 6. We are not changing the rural payment adjustment for CY 2011. We estimate that the combination of updated wage data and nationwide application of rural floor budget neutrality will redistribute payment among regions. We also updated the list of counties qualifying for the section 505 out-migration adjustment. Overall, we estimate that urban hospitals will experience no change from CY 2010 to CY 2011, and that rural hospitals will experience a decrease of 0.2 percent as a result of the updated wage indices. We estimate that hospitals in rural New England States and rural West South Central States will experience increases of 0.8 and 0.7 percent, respectively, while other rural regions will experience decreases from 0.6 to 0.1 percent. We estimate that hospitals located in urban New England, East North Central, West South Central and Pacific regions will experience increases of 0.1 to 0.5 percent while other urban regions will experience no change or decreases of 0.4 to 0.1 percent.

Column 4: All Budget Neutrality Changes Combined with the Adjusted OPD Fee Schedule Increase

We estimate that the addition of the adjusted OPD fee schedule increase factor of 2.35 percent (which includes the reduction to the OPD fee schedule update factor of a 0.25 percentage point as required by section 3401(i), 10319(g), and section 1105(e) of the Affordable Care Act) will mitigate the negative impacts on hospital payments for CY 2011 created by the budget neutrality adjustments made in Columns 2 and 3. Rural hospitals with fewer than 43,000 lines experience the smallest increases of between 1.4 and 1.9 percent. In general, Column 4 shows that all hospitals will experience an estimated increase of 2.6 percent, attributable to the 2.35 percent adjusted OPD fee schedule increase factor combined with the budget neutrality adjustments.

Overall, we estimate that these changes will increase payments to urban hospitals by 2.7 percent. We estimate that large urban hospitals will experience an increase of 2.8 percent, and "other" urban hospitals will experience a 2.6 percent increase. We estimate that rural hospitals will experience a 2.2 percent increase as a result of the adjusted OPD fee schedule increase factor and other budget neutrality adjustments. We estimate that urban hospitals that bill less than 5,000 lines of OPPS services will experience the largest increase of 4.8 percent and that rural hospitals will experience increases of 1.4 to 2.2 percent.

Among teaching hospitals, we estimate that the observed impacts resulting from the adjusted OPD fee schedule increase factor and other budget neutrality adjustments will include an increase of 2.8 and 2.6 percent, respectively, for major and minor teaching hospitals.

Classifying hospitals by type of ownership suggests that proprietary and government hospitals will experience estimated increases of 2.7 percent, while voluntary hospitals will experience increases of 2.6 percent.

Column 5: Frontier State Wage Index Adjustment

This column shows the impact of all budget neutrality adjustments, application of the 2.35 percent adjusted OPD fee schedule increase factor, and the non-budget neutral impact of applying the frontier State wage adjustment (that is, the frontier State wage index change in addition to all changes reflected in column 4). In general, we estimate that all facilities will see a combined increase of 2.4 percent and that all hospitals will see a combined increase of 2.7 percent. Hospitals in the rural Mountain Region will see an increase of 4.0 percent as a result of the combined effects of all budget neutrality adjustments, application of the 2.35 percent adjusted OPD fee schedule increase factor, and the non-budget neutral impact of applying the frontier State wage adjustment.

Column 6: All Changes for CY 2011

Column 6 compares all changes for CY 2011 to estimated final payment for CY 2010, including the change in the outlier threshold, payment reductions for hospitals that failed to meet the HOP QDRP reporting requirements, the influence of the expiration of the section 508 wage adjustment, and the difference in pass-through estimates that are not included in the combined percentages shown in Column 5. This column includes estimated payment for a handful of hospitals receiving reduced payment because they did not meet their hospital outpatient quality measure reporting requirements; however, we estimate that the anticipated change in payment between CY 2010 and CY 2011 for these hospitals will be negligible. (We further discuss the estimated impacts of hospitals' failure to meet these requirements below in section XX.D. of this final rule with comment period.) Overall, we estimate that facilities will experience an increase of 2.5 percent under this final rule with comment period in CY 2011 relative to total spending in CY 2010. The projected 2.5 percent increase for all facilities in Column 6 of Table 66 reflects the 2.35 percent OPD fee schedule increase, less 0.01 percent for the change in the pass-through estimate between CY 2010 and CY 2011, plus 0.15 percent for the difference in estimated outlier payments between CY 2010 (0.85 percent) and CY 2011 (1.0 percent), and less 0.06 percent due to the expiration of the special, non-budget neutral wage index payments made under section 508, plus 0.10 percent due to the frontier wage index adjustment. When we exclude cancer and children's hospitals (which are held harmless to their pre-OPPS costs) and CMHCs, the estimated increase is 2.8 percent.

We estimate that the combined effect of all changes for CY 2011 will increase payments to urban hospitals by 2.9 percent. We estimate that large urban hospitals will experience a 2.9 percent increase, while "other" urban hospitals will experience an increase of 2.8 percent. We estimate that urban hospitals that bill less than 5,000 lines of OPPS services will experience an increase of 5.1 percent, and we estimate that urban hospitals that bill 5,000 or more lines of OPPS services will experience increases between 2.7 percent and 3.6 percent.

Overall, we estimate that rural hospitals will experience a 2.4 percent increase as a result of the combined effects of all changes for CY 2011. We estimate that rural hospitals that bill less than 5,000 lines of OPPS services will experience an increase of 3.6 percent and rural hospitals that bill 5,000 or more lines of OPPS services will experience increases ranging from 1.9 percent to 2.5 percent.

Among teaching hospitals, we estimate that the impacts resulting from the combined effects of all changes will include an increase of 3.0 percent for major teaching hospitals and 2.9 percent for minor teaching hospitals.

Classifying hospitals by type of ownership, we estimate that voluntary and proprietary hospitals will gain 2.8 percent, and that governmental hospitals will experience an increase of 2.9 percent.

4. Estimated Effects of This Final Rule With Comment Period on CMHCs

The last line of Table 66 demonstrates the isolated impact on CMHCs. CMHCs are currently paid under two APCs for services under the OPPS: APC 0172 (Level 1 Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). This final rule with comment period further refines payment within these partial hospitalization APCs for CY 2011 by providing two payment rates for partial hospitalization services for each provider type (CMHCs and hospital-based PHPs). Specifically, APC 0172 is retitled: "Level I Partial Hospitalization (3 services) for CMHCs;" APC 0173 is retitled: "Level II Partial Hospitalization (4 or more services) for CMHCs;" new APC 0175 is titled: "Level I Partial Hospitalization (3 services) for Hospital-Based PHPs" and new APC 0176 is titled: "Level II Partial Hospitalization (4 or more services) for Hospital-Based PHPs." We are adopting payment rates for each APC based on the cost data derived from claims and cost reports for the provider type to which the APC is specific and are providing a 2-year transition to CMHC rates based solely on CMHC data for the two CMHC PHP per diem rates. For CY 2011, we are calculating the CMHC PHP APC Level I and Level II rates by taking 50 percent of the difference between the CY 2010 final hospital-based medians and the CY 2011 final CMHC medians and adding that number to the CY 2011 final CMHC medians. We modeled the impact of this APC policy change assuming that CMHCs will continue to provide the same number of days of PHP care, with each day having either three services or four or more services, as seen in the CY 2009 claims data. We excluded days with one or two services. Because the relative weights for APC 0172 (Level 1 Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)) both decline in CY 2011 to reflect CMHC cost data for partial hospitalization services provided by CMHCs under this final rule with comment period, we estimate that there will be a 24.1 percent decrease in payments to CMHCs due to these APC policy changes (shown in Column 2).

Column 3 shows that the estimated impact of adopting the CY 2011 wage index values will result in a 0.9 percent increase in payments to CMHCs. We note that all providers paid under the OPPS, including CMHCs, will receive a 2.35 percent OPD fee schedule increase. Combining this OPD fee schedule increase, along with changes in APC policy for CY 2011 and the CY 2011 wage index updates, changes in outlier and pass-though payments, and the expiration of section 508 wages, we estimate that the combined impact on CMHCs for CY 2011 will be a 21.1 percent decrease in payment.

The impact on hospitals of the changes to payment rates to hospitals for partial hospitalization services is reflected in the impact of all changes on hospitals.

All providers paid under the OPPS will receive a 2.35 percent OPD fee schedule increase under this policy. Combining this OPD fee schedule increase, along with changes in APC policy for CY 2011 and the CY 2011 wage index updates, changes in outlier and pass-through payments, and the expiration of section 508 wages, we estimate that the combined impact hospitals within the PPS system will be a 2.5 percent increase in total payment for CY 2011.

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TABLE 66.--ESTIMATED IMPACT OF THE FINAL CY 2011 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	Comb (cols 2,3) with Market Basket Update (4)	Frontier Wage Index Adjustment (5)	All Changes (6)
ALL FACILITIES *	4,185	0.0	0.0	2.3	2.4	2.5
ALL HOSPITALS	3,906	0.3	0.0	2.6	2.7	2.8
(excludes hospitals permanently held harmless and CMHCs)						
URBAN HOSPITALS	2,919	0.3	0.0	2.7	2.8	2.9
LARGE URBAN (GT 1 MILL.)	1,585	0.3	0.1	2.8	2.8	2.9
OTHER URBAN (LE 1 MILL.)	1,334	0.3	0.0	2.6	2.8	2.8
RURAL HOSPITALS	987	0.0	-0.2	2.2	2.4	2.4
SOLE COMMUNITY	397	0.0	-0.4	2.0	2.4	2.4
OTHER RURAL	590	0.1	-0.1	2.3	2.4	2.5
BEDS (URBAN)						
0 - 99 BEDS	987	0.3	0.0	2.7	2.8	2.9
100-199 BEDS	864	0.2	0.1	2.6	2.7	2.8
200-299 BEDS	451	0.4	0.0	2.7	2.9	2.9
300-499 BEDS	421	0.4	0.1	2.8	2.9	2.9
500 + BEDS	196	0.3	0.0	2.6	2.6	2.8
BEDS (RURAL)						
0 - 49 BEDS	356	-0.5	0.0	1.9	2.1	2.2
50- 100 BEDS	375	-0.1	-0.4	1.9	2.1	2.2
101- 149 BEDS	149	0.0	-0.1	2.3	2.5	2.5

	Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	Comb (cols 2,3) with Market Basket Update (4)	Frontier Wage Index Adjustment (5)	All Changes (6)
150- 199 BEDS	62	0.3	-0.1	2.6	3.1	3.1
200 + BEDS	45	0.4	-0.3	2.5	2.5	2.5
VOLUME (URBAN)						
LT 5,000 Lines	595	2.2	0.3	4.8	4.8	5.1
5,000 - 10,999 Lines	146	0.7	0.3	3.4	3.4	3.6
11,000 - 20,999 Lines	233	0.3	0.1	2.7	2.8	2.9
21,000 - 42,999 Lines	509	0.1	0.1	2.6	2.6	2.7
42,999 - 89,999 Lines	708	0.3	0.1	2.7	2.8	2.8
GT 89,999 Lines	728	0.3	0.0	2.7	2.8	2.9
VOLUME (RURAL)						
LT 5,000 Lines	73	-1.2	0.3	1.4	3.3	3.6
5,000 - 10,999 Lines	79	-0.9	0.2	1.6	1.7	1.9
11,000 - 20,999 Lines	183	-0.6	-0.1	1.6	1.8	1.9
21,000 - 42,999 Lines	314	-0.4	-0.1	1.9	2.1	2.2
GT 42,999 Lines	248	0.1	-0.2	2.2	2.4	2.5
REGION (URBAN)						
NEW ENGLAND	149	0.3	0.1	2.7	2.7	2.8
MIDDLE ATLANTIC	362	0.3	-0.3	2.4	2.4	2.5
SOUTH ATLANTIC	461	0.4	0.0	2.7	2.7	2.8
EAST NORTH CENT.	471	0.3	0.1	2.7	2.7	2.8
EAST SOUTH CENT.	181	0.2	-0.1	2.4	2.4	2.4
WEST NORTH CENT.	190	0.4	-0.2	2.6	3.3	3.4
WEST SOUTH CENT.	469	0.4	0.2	3.0	2.9	3.1
MOUNTAIN	198	0.2	-0.1	2.5	2.9	3.0
PACIFIC	390	0.4	0.5	3.2	3.2	3.4
PUERTO RICO	48	-0.5	-0.4	1.4	1.4	1.6

	Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	Comb (cols 2,3) with Market Basket Update (4)	Frontier Wage Index Adjustment (5)	All Changes (6)
REGION (RURAL)						
NEW ENGLAND	26	0.5	0.8	3.7	3.7	3.7
MIDDLE ATLANTIC	67	0.3	-0.4	2.2	2.2	2.4
SOUTH ATLANTIC	165	0.0	-0.4	1.9	1.9	2.0
EAST NORTH CENT.	127	0.1	-0.6	1.8	1.8	1.9
EAST SOUTH CENT.	176	-0.2	0.0	2.1	2.1	2.1
WEST NORTH CENT.	102	0.4	-1.0	1.8	2.9	2.9
WEST SOUTH CENT.	224	-0.2	0.7	2.8	2.8	2.9
MOUNTAIN	70	-0.2	-0.1	2.0	4.0	3.9
PACIFIC	30	-0.2	-0.3	1.8	1.8	1.8
TEACHING STATUS						
NON-TEACHING	2,925	0.2	0.0	2.6	2.7	2.7
MINOR	694	0.3	-0.1	2.6	2.8	2.9
MAJOR	287	0.4	0.0	2.8	2.8	3.0
DSH PATIENT PERCENT						
0	7	2.3	1.2	5.8	5.8	5.8
GT 0 - 0.10	369	0.5	0.0	2.8	2.9	2.9
0.10 - 0.16	396	0.3	0.2	2.8	2.9	2.9
0.16 - 0.23	738	0.2	-0.1	2.4	2.7	2.7
0.23 - 0.35	1,021	0.3	-0.1	2.6	2.6	2.7
GE 0.35	771	0.4	0.1	2.8	2.8	3.0
DSH NOT AVAILABLE **	604	-0.7	0.3	1.9	1.9	2.0
URBAN TEACHING/DSH						
TEACHING & DSH	893	0.4	0.0	2.7	2.8	2.9
NO TEACHING/DSH	1,448	0.3	0.1	2.7	2.8	2.8
NO TEACHING/NO DSH	7	2.3	1.2	5.8	5.8	5.8
DSH NOT AVAILABLE**	571	-0.4	0.3	2.3	2.2	2.4
TYPE OF						

	Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	Comb (cols 2,3) with Market Basket Update (4)	Frontier Wage Index Adjustment (5)	All Changes (6)
OWNERSHIP						
VOLUNTARY	2,078	0.3	0.0	2.6	2.7	2.8
PROPRIETARY	1,260	0.3	0.1	2.7	2.8	2.8
GOVERNMENT	568	0.3	0.0	2.7	2.7	2.9
CMHCs	217	-24.1	0.9	-21.1	-21.1	-21.1

Column (1) shows total hospitals.

Column (2) shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2009 hospital claims data.

Column (3) shows the budget neutral impact of updating the wage index by applying the FY 2011 hospital inpatient wage index. We are not making any changes to the rural adjustment.

Column (4) shows the impact of all budget neutrality adjustments and the addition of the 2.35% adjusted OPD fee schedule increase factor (2.6 percent market basket reduced by 0.25 percentage point in accordance with the Affordable Care Act).

Column (5) shows the non-budget neutral impact of applying the frontier adjustment, after application of the adjusted OPD fee schedule increase factor

Column (6) shows the additional adjustments to the conversion factor resulting from a change in the pass-through estimate and adds outlier payments. This column also shows the expiration of section 508 wages on September 30, 2010 and the application of the frontier wage adjustment for CY 2011.

*These 4,185 providers include children and cancer hospitals, which are held harmless to pre-BBA payments, and CMHCs.

** Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

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6. Estimated Effect of This Final Rule With Comment Period on Beneficiaries

For services for which the beneficiary pays a copayment of 20 percent of the payment rate, the beneficiary share of payment will increase for services for which the OPPS payments will rise and will decrease for services for which the OPPS payments will fall. For example, for a service assigned to Level IV Needle Biopsy/Aspiration Except Bone Marrow (APC 0037) in the CY 2010 OPPS, the national unadjusted copayment is $228.76, and the minimum unadjusted copayment is $208.97. For CY 2011, the national unadjusted copayment for APC 0037 will be $228.76, the same rate in effect for CY 2010. The minimum unadjusted copayment for APC 0037 will be $216.29 or 20 percent of the CY 2011 national unadjusted payment rate for APC 0037 of $1,081.42. The minimum unadjusted copayment will rise because the payment rate for APC 0037 will rise for CY 2011. In all cases, the statute limits beneficiary liability for copayment for a procedure to the hospital inpatient deductible for the applicable year. The CY 2010 hospital inpatient deductible is $1,100. The CY 2011 hospital inpatient deductible was not known at the time this final rule was written.

In order to better understand the impact of changes in copayment on beneficiaries, we modeled the percent change in total copayment liability using CY 2009 claims. We estimate, using the claims of the 4,185 hospitals and CMHCs on which our modeling is based, that total beneficiary liability for copayments will decline as an overall percentage of total payments, from 22.3 percent in CY 2010 to 21.9 percent in CY 2011.

7. Conclusion

The changes in this final rule with comment period will affect all classes of hospitals and CMHCs. We estimate that some classes of hospitals will experience significant gains and others less significant gains, but all classes of hospitals will experience positive updates in OPPS payments in CY 2011 with one exception. We estimate that CMHCs will see an overall decrease in payment of 21.1 percent during this first year of a two-year transition to payment rates for partial hospitalization services

at CMHCs based on cost report and claims data submitted by CMHCs.

Table 66 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements that will result in a 2.5 percent increase in payments for all services paid under the OPPS in CY 2011, after considering all changes to APC reconfiguration and recalibration, as well as the adjusted market basket increase, wage index changes, including the frontier State wage index adjustment and the expiration of section 508 wage index reclassifications, estimated payment for outliers, and changes to the pass-through payment estimate. The accompanying discussion, in combination with the rest of this final rule with comment period, constitutes a regulatory impact analysis.

8. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 67, we have prepared an accounting statement showing the CY 2011 estimated hospital OPPS incurred benefit impact associated with the CY 2011 OPD fee schedule increase shown in this final rule with comment period based on the FY 2011 President's Budget. All estimated impacts are classified as transfers.

TABLE 67—ACCOUNTING STATEMENT: CY 2011 ESTIMATED HOSPITAL OPPS TRANSFERS FROM CY 2010 TO CY 2011 ASSOCIATED WITH THE FINAL CY 2011 HOSPITAL OUTPATIENT OPD FEE SCHEDULE INCREASE

Category	Transfers
Annualized Monetized Transfers.	$0.7 billion.
From Whom to Whom.	Federal Government to outpatient hospitals and other providers who received payment under the hospital OPPS.
Total	$0.7 billion.

C. Effects of ASC Payment System Changes in This Final Rule With Comment Period

On August 2, 2007, we published in the **Federal Register** the final rule for the revised ASC payment system, effective January 1, 2008 (72 FR 42470). In that final rule, we adopted the methodologies to set payment rates for covered ASC services to implement the revised payment system so that it will be designed to result in budget neutrality as required by section 626 of Public Law 108–173; established that the OPPS relative payment weights will be the basis for payment and that we will update the system annually as part of the OPPS rulemaking cycle; and provided that the revised ASC payment rates will be phased in over 4 years. During the 4-year transition to full implementation of the ASC payment rates, payments for surgical procedures performed in ASCs that were on the CY 2007 ASC list of covered surgical procedures were made using a blend of the CY 2007 ASC payment rate and the ASC payment rate calculated according to the ASC standard ratesetting methodology for the applicable transitional year. In CY 2009, we paid ASCs using a 50/50 blend, in which payment was calculated by adding 50 percent of the CY 2007 ASC rate for a surgical procedure on the CY 2007 ASC list of covered surgical procedures and 50 percent of the CY 2009 ASC rate calculated according to the ASC standard ratesetting methodology for the same procedure. For CY 2010, we transitioned the blend to a 25/75 blend of the CY 2007 ASC rate and the CY 2010 ASC payment rate calculated according to the ASC standard ratesetting methodology. In CY 2011, we will pay ASCs for all covered surgical procedures, including those on the CY 2007 ASC list, at the ASC payment rates calculated according to the ASC standard ratesetting methodology.

ASC payment rates are calculated by multiplying the ASC conversion factor by the ASC relative payment weight. As discussed fully in section XV. of this final rule with comment period, we set the CY 2011 ASC relative payment weights by scaling CY 2011 ASC relative payment weights by the ASC scaler of 0.9238. The estimated effects of the updated relative payment weights on payment rates during this first year of full implementation of the ASC payment rates calculated according to the ASC standard ratesetting methodology are varied and are reflected in the estimated payments displayed in Tables 68 and 69 below.

Beginning in CY 2011, section 3401 of the Affordable Care Act requires that the annual update to the ASC payment system, which is the consumer price index for all urban consumers (CPI–U), be reduced by the productivity adjustment. The Affordable Care Act defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period). We calculated the CY 2011 ASC conversion factor by adjusting the CY 2010 ASC conversion factor by 0.9996 to account for changes in the pre-floor and pre-reclassified hospital wage indices between CY 2010 and CY 2011 and by applying the CY 2011 MFP-adjusted CPI–U of 0.2 percent (1.5 percent CPI–U minus 1.3 percent MFP). The CY 2011 ASC conversion factor is $41.939.

1. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen specific options are discussed throughout this final rule with comment period. Some of the major ASC issues discussed in this final rule with comment period and the options considered are discussed below.

a. Alternatives Considered for Office-Based Procedures

According to our final policy for the revised ASC payment system, we designate as office-based those procedures that are added to the ASC list of covered surgical procedures in CY 2008 or later years and that we determine are predominantly performed in physicians' offices based on consideration of the most recent available volume and utilization data for each individual procedure HCPCS code and, if appropriate, the clinical characteristics, utilization, and volume of related HCPCS codes. We establish payment for procedures designated as office-based at the lesser of the MPFS nonfacility practice expense payment amount or the ASC rate developed according to the standard methodology of the revised ASC payment system.

In developing this final rule with comment period, we reviewed the full CY 2009 utilization data for all surgical procedures added to the ASC list of covered surgical procedures in CY 2008 or later years and for those procedures for which the office-based designation is temporary in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60605 through 60608). Based on that review, and as discussed in section XV.C.1.b. of this final rule with comment period, we are newly designating two surgical procedures as permanently office-based and making permanent the office-based designations of three existing surgical procedures that have temporary office-based designations in CY 2010. In addition, we are making temporary office-based designations for seven procedures in CY 2011 that were designated as temporarily office-based for CY 2010. We considered two alternatives in developing this policy.

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Part II—Continued

Department of Health and Human Services

Center for Medicare & Medicaid Services

42 CFR Parts 410, 411, 412, et al.

Medicare Program: Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Payments to Hospitals for Graduate Medical Education Costs; Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations; Payment for Certified Registered Nurse Anesthetist Services Furnished in Rural Hospitals and Critical Access Hospitals; Final Rule

The first alternative we considered was to make no change to the procedure payment designations. This would mean that we would pay for the five procedures we are designating as permanently office-based and the seven procedures we are designating as temporarily office-based at an ASC payment rate calculated according to the standard ratesetting methodology of the revised ASC payment system. We did not select this alternative because our analysis of the data and our clinical review indicated that all five procedures we are designating as permanently office-based, as well as the seven procedures that we are designating temporarily as office-based, are considered to be predominantly performed in physicians' offices. Consistent with our final policy adopted in the August 2, 2007 final rule (72 FR 42509 through 42513), we were concerned that making payments at the standard ASC payment rate for the five procedures designated as permanently office-based and seven procedures designated as temporarily office-based could create financial incentives for the procedures to shift from physicians' offices to ASCs for reasons unrelated to clinical decisions regarding the most appropriate setting for surgical care. Further, consistent with our policy, we believe that when adequate data become available to make permanent determinations about procedures with temporary office-based designations, maintaining the temporary designation is no longer appropriate.

The second alternative we considered and the one we selected for CY 2011 is to designate two additional procedures as permanently office-based for CY 2011 and to make permanent the office-based designations of three of the procedures with temporary office-based designations in CY 2010. We also are designating seven procedures as temporarily office-based in CY 2011 that were designated as temporarily office-based for CY 2010. We chose this alternative because our claims data and clinical review indicate that these procedures could be considered to be predominantly performed in physicians' offices. We believe that designating these procedures as office-based, which results in the CY 2011 ASC payment rate for these procedures potentially being capped at the CY 2011 physicians' office rate (that is, the MPFS nonfacility practice expense payment amount), if applicable, is an appropriate step to ensure that Medicare payment policy does not create financial incentives for such procedures to shift unnecessarily from physicians' offices to ASCs, consistent with our final policy adopted in the August 2, 2007 final rule.

b. Alternatives Considered for Covered Surgical Procedures

According to our final policy for the revised ASC payment system, we designate as covered all surgical procedures that we determine would not be expected to pose a significant risk to beneficiary safety or would not be expected to require an overnight stay when performed on Medicare beneficiaries in an ASC.

In developing this final rule with comment period, we reviewed the clinical characteristics and full CY 2009 utilization data, if applicable, for all procedures reported by Category III CPT codes implemented July 1, 2010, and surgical procedures that were excluded from ASC payment for CY 2010. Based on this review, we identified 8 new surgical procedures described by Category III CPT codes that were new for July 2010 and 6 surgical procedures excluded from ASC payment for CY 2010, that we determined were appropriate for addition to the ASC list of covered surgical procedures. We considered two alternatives in developing this policy.

The first alternative we considered was to make no change to the CY 2010 ASC list of covered surgical procedures. We did not choose this alternative because our analysis of data and clinical review indicated that the 14 procedures we are designating as covered surgical procedures for CY 2011 would not be expected to pose a significant risk to beneficiary safety in ASCs and would not be expected to require an overnight stay. Consistent with our final policy, we were concerned that by continuing to exclude them from the list of ASC covered surgical procedures, we may unnecessarily limit beneficiaries' access to the services in the most clinically appropriate settings.

The second alternative we considered and the one we selected for CY 2011 was to designate 14 additional procedures as ASC covered surgical procedures for CY 2011. We chose this alternative because our claims data and clinical review indicate that these procedures will not be expected to pose a significant risk to beneficiary safety and will not be expected to require an overnight stay, and thus they meet the criteria for inclusion on the list of ASC covered surgical procedures. We believe that adding these procedures to the list of covered surgical procedures is an appropriate step to ensure that beneficiary access to services is not limited unnecessarily.

c. Alternatives Considered for the Extension of Waiver of Deductible to Services Furnished in Connection With or in Relation to a Colorectal Screening Test That Becomes Diagnostic

Section 4104(c)(2) of the Affordable Care Act waives the deductible with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test. We are finalizing our proposal, without modification, for CY 2011 that the deductible be waived for all surgical services furnished in an ASC on the same date as a planned screening colonoscopy or planned flexible sigmoidoscopy as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test (we note that barium enemas are not ASC covered ancillary or surgical procedures). As discussed in detail under the alternatives considered for the OPPS (section XX.B.1.a. of this final rule with comment period), we considered three alternatives for the extension of waiver of deductible to services furnished in connection with or in relation to a colorectal screening test that becomes diagnostic for CY 2011. The first alternative we considered, but did not propose for the reasons previously discussed, was to define a limited set of colonoscopy codes to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy or screening flexible sigmoidoscopy. The second alternative we considered, but did not propose for the reasons previously discussed, was to define a broader, but still limited set of codes (for example, selected surgical services) to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy or screening flexible sigmoidoscopy. The third alternative we considered, and the one we are selecting for CY 2011, is to apply the waiver to any surgical procedure on the same date as a screening colonoscopy or flexible sigmoidoscopy performed in an ASC that ASCs report is "in connection with, as a result of, and in the same clinical encounter as the screening test." As we discuss in detail in section XII.B.3., we have created HCPCS modifier PT that ASCs will append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code when the screening test

becomes a diagnostic service. As already discussed, we chose this alternative because we believe it provides the greatest ease of public understanding and ASC application. We believe that this alternative is appropriate because we believe that it will be very rare for an unrelated surgery to occur on the same date as one of these scheduled screening tests. Moreover, we believe that the risk of improper expenditures will be very small under this policy because it is the deductible, and not the coinsurance, that is waived for the related procedures other than the screening tests (that is, the Part B deductible is a fixed amount that the beneficiary pays before Medicare begins to pay and typically will be met after receiving one to two services).

2. Limitations of Our Analysis

Presented here are the projected effects of the changes for CY 2011 on Medicare payment to ASCs. A key limitation of our analysis is our inability to predict changes in ASC service mix between CY 2009 and CY 2011 with precision. We believe that the net effect on Medicare expenditures resulting from the CY 2011 changes will be small in the aggregate for all ASCs. However, such changes may have differential effects across surgical specialty groups as ASCs continue to adjust to the payment rates based on the policies of the revised ASC payment system. We are unable to accurately project such changes at a disaggregated level. Clearly, individual ASCs will experience changes in payment that differ from the aggregated estimated impacts presented below.

3. Estimated Effects of This Final Rule With Comment Period on Payments to ASCs

Some ASCs are multispecialty facilities that perform the gamut of surgical procedures, from excision of lesions to hernia repair to cataract extraction; others focus on a single specialty and perform only a limited range of surgical procedures, such as eye, digestive system, or orthopedic procedures. The combined effect on an individual ASC of the update to the CY 2011 payments 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 provides different services in the coming year. The following discussion presents tables that display estimates of the impact of the CY 2011 update to the revised ASC payment system on Medicare payments to ASCs, assuming the same mix of services as reflected in our CY 2009 claims data. Table 68 depicts the estimated aggregate percent change in payment by surgical specialty or ancillary items and services group by comparing estimated CY 2010 payments to estimated CY 2011 payments, and Table 69 shows a comparison of estimated CY 2010 payments to estimated CY 2011 payments for procedures that we estimate will receive the most Medicare payment in CY 2011.

Table 68 shows the estimated effects on aggregate Medicare payments under the revised ASC payment system by surgical specialty or ancillary items and services group. We have aggregated the surgical HCPCS codes by specialty group, grouped all HCPCS codes for covered ancillary items and services into a single group, and then estimated the effect on aggregated payment for surgical specialty and ancillary items and services groups. The groups are sorted for display in descending order by estimated Medicare program payment to ASCs. The following is an explanation of the information presented in Table 68.

- Column 1—*Surgical Specialty or Ancillary Items and Services Group* indicates the surgical specialty into which ASC procedures are grouped or the ancillary items and services group which includes all HCPCS codes for covered ancillary items and services. To group surgical procedures by surgical specialty, we used the CPT code range definitions and Level II HCPCS codes and Category III CPT codes as appropriate, to account for all surgical procedures to which the Medicare program payments are attributed.
- Column 2—*Estimated ASC Payments* were calculated using CY 2009 ASC utilization (the most recent full year of ASC utilization) and CY 2010 ASC payment rates. The surgical specialty and ancillary items and services groups are displayed in descending order based on estimated CY 2010 ASC payments.
- Column 3—*Estimated CY 2011 Percent Change (Fully Implemented Payment Rates)* is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty or ancillary items and services group that will be attributable to updates to ASC payment rates for CY 2011 compared to CY 2010.

As seen in Table 68, we estimate that the update to ASC rates for CY 2011 will result in a 0 percent decrease in aggregate payment amounts for eye and ocular adnexa procedures, a 4 percent decrease in aggregate payment amounts for digestive system procedures, and a 2 percent increase in aggregate payment amounts for nervous system procedures.

Generally, for the surgical specialty groups that account for less ASC utilization and spending, we estimate that the payment effects of the CY 2011 update are positive. We estimate that ASC payments for procedures in those surgical specialties will increase in CY 2011. For instance, we estimate that, in the aggregate, payment for integumentary system procedures will increase by 5 percent under the CY 2011 rates. We estimate similar effects for genitourinary, cardiovascular, musculoskeletal, respiratory, hematologic and lymphatic systems, and auditory system procedures as well.

An estimated increase in aggregate payment for the specialty group does not mean that all procedures in the group will experience increased payment rates. For example, the estimated modest increase for CY 2011 for nervous system procedures is likely due to increase in the ASC payment weight for some of the high volume procedures, such as CPT code 64721 (Neuroplasty and/or transposition; median nerve at carpal tunnel).

Also displayed in Table 68 is a separate estimate of Medicare ASC payments for the group of separately payable covered ancillary items and services. Payment for the current class of New Technology Intraocular Lenses (NTIOLs) is captured under this category. The current active class for NTIOLs for reduced spherical aberration expires on February 26, 2011. Because we did not find sufficient evidence of clinical benefit to implement a new class of NTIOLs for blue-light filtering to reduce glare, as discussed in section XV.E. of this final rule with comment period, we redistributed payment previously dedicated to separately payment for NTIOLs to other services for CY 2011. Therefore, we estimate that aggregate payments for these items and services will decrease by 58 percent for CY 2011. The payment estimates for the covered surgical procedures include the costs of packaged ancillary items and services. In rules for years prior to CY 2010, we did not have ASC payment data for covered ancillary items and services because, prior to CY 2008, they were paid under other fee schedules or packaged into payment for the covered surgical procedures. Beginning with the CY 2010 OPPS/ASC rulemaking, we have utilization data for those services as well as for all of the covered surgical procedures provided in ASCs under the revised payment system.

TABLE 68—ESTIMATED IMPACT OF THE FINAL CY 2011 UPDATE TO THE ASC PAYMENT SYSTEM ON AGGREGATE CY 2011 MEDICARE PROGRAM PAYMENTS BY SURGICAL SPECIALITY OR ANCILLARY ITEMS AND SERVICES GROUP

Surgical specialty group	Estimated CY 2010 ASC payments (in millions)	Estimated CY 2011 percent change (fully implemented)
(1)	(2)	(3)
Total	$3,257	0
Eye and ocular adnexa	1,426	0
Digestive system	699	−4
Nervous system	391	2
Musculoskeletal system	350	12
Genitourinary system	129	9
Integumentary system	122	5
Ancillary items and services	68	−58
Respiratory system	36	17
Cardiovascular system	24	7
Auditory system	8	9
Hematologic & lymphatic systems	4	16

Table 69 below shows the estimated impact of the updates to the revised ASC payment system on aggregate ASC payments for selected surgical procedures during CY 2011. The table displays 30 of the procedures receiving the greatest estimated CY 2010 aggregate Medicare payments to ASCs. The HCPCS codes are sorted in descending order by estimated CY 2010 program payment.

- Column 1–*HCPCS code*.
- Column 2–*Short Descriptor* of the HCPCS code.
- Column 3–*Estimated CY 2010 Allowed Charges* were calculated using CY 2009 ASC utilization (the most recent full year of ASC utilization) and the CY 2010 ASC payment rates. The estimated CY 2010 allowed charges are expressed in millions of dollars.
- Column 4–*Estimated CY 2011 Percent Change (Fully Implemented Payment Rates)* reflects the percent differences between the estimated ASC payment for CY 2010 and the estimated payment for CY 2011 based on the update.

As displayed in Table 69, 22 of the 30 procedures with the greatest estimated aggregate CY 2010 Medicare payment are included in the 3 surgical specialty groups that are estimated to account for the most Medicare payment to ASCs in CY 2011, specifically eye and ocular adnexa, digestive system, and nervous system surgical groups. Consistent with the estimated payment effects on the surgical specialty groups displayed in Table 68, the estimated effects of the CY 2011 update on ASC payment for individual procedures shown in Table 69 are varied.

The ASC procedure for which the most Medicare payment is estimated to be made in CY 2010 is the cataract removal procedure reported with CPT code 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)). We estimate that the update to the ASC rates will result in a 1 percent payment decrease for this procedure in CY 2011. The estimated payment effects on two of the four other eye and ocular adnexa procedures included in Table 69 are more significant. We estimate that the payment rate for CPT code 66821 (Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)) will decrease by 7 percent and payment for CPT code 67904 (Repair eyelid defect) will increase by 11 percent.

We estimate that the payment rates for all of the digestive system procedures included in Table 69 will decrease by 0 to 8 percent in CY 2011. Those estimated decreases are consistent with decreases in the previous 3 years under the revised ASC payment system and are expected because, under the previous ASC payment system, the payment rates for many high volume endoscopy procedures were almost the same as the payments for the procedures under the OPPS.

The estimated effects of the CY 2011 update on the nine nervous system procedures for which the most Medicare ASC payment is estimated to be made in CY 2010 will be variable. Our estimates indicate that the CY 2011 update will result in payment increases of 2 to 11 percent for 5 of the 9 procedures and result in a 1 percent decrease for the other 4 nervous system procedures. The nervous system procedures for which we estimate a positive effect on CY 2010 payments, include CPT codes 64721 (Neuroplasty and/or transposition; median nerve at carpal tunnel) and 63685 (Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling), which are expected to have payment increases of 11 percent and 7 percent respectively.

The estimated payment effects for most of the remaining procedures listed in Table 69 will be positive. For example, the payment rates for musculoskeletal CPT codes 29880 (Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal shaving)) and 29881 (Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)) are estimated to increase 11 percent over the CY 2010 transitional payment rates. Musculoskeletal procedures are expected to account for a greater percentage of CY 2011 Medicare ASC spending as we estimate that payment for procedures in that surgical specialty group will increase under the revised payment system in CY 2011.

TABLE 69—ESTIMATED IMPACT OF THE FINAL CY 2011 UPDATE TO THE ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR SELECTED PROCEDURES

CPT/ HCPCS Code * (1)	Short descriptor (2)	Estimated CY 2010 Allowed charges (in millions) (3)	Estimated CY 2011 percent change (fully implemented payment) (4)
66984	Cataract surg w/ iol, 1 stage	$1,095	−1
43239	Upper GI endoscopy, biopsy	163	−7
45380	Colonoscopy and biopsy	130	−5
45378	Diagnostic colonoscopy	110	−5
45385	Lesion removal colonoscopy	88	−5
66982	Cataract surgery, complex	74	−1
62311	Inject spine l/s (cd)	67	−1
66821	After cataract laser surgery	63	−7
64483	Inj foramen epidural l/s	62	−1
15823	Revision of upper eyelid	39	−3
64493	Inj paravert f jnt l/s 1 lev	36	2
29826	Shoulder arthroscopy/ surgery	32	18
G0105	Colorectal scrn; hi risk ind	32	−8
63650	Implant neuroelectrodes	31	6
45384	Lesion remove colonoscopy	28	−5
29881	Knee arthroscopy/ surgery	27	11
G0121	Colon ca scrn not hi rsk ind	27	−8
64721	Carpal tunnel surgery	26	11
43235	Uppr gi endoscopy, diagnosis	24	0
29880	Knee arthroscopy/ surgery	22	11
52000	Cystoscopy	21	−2
63685	Insrt/redo spine n generator	21	7
64622	Destr paravertebrl nerve l/s	17	4
28285	Repair of hammertoe	17	13
62310	Inject spine c/t	15	−1
67904	Repair eyelid defect	15	11
26055	Incise finger tendon sheath	14	7
64623	Destr paravertebral n add-on	13	−1
67042	Vit for macular hole	13	−1
50590	Fragmenting of kidney stone	13	−2

* Note that HCPCS codes proposed for deletion for CY 2011 are not displayed in this table.

The previous ASC payment system served as an incentive to ASCs to focus on providing procedures for which they determined Medicare payments will support their continued operation. We note that, historically, the ASC payment rates for many of the most frequently performed procedures in ASCs were similar to the OPPS payment rates for the same procedures. Conversely, procedures with ASC payment rates that were substantially lower than the OPPS rates have historically been performed least often in ASCs. We believed that the revised ASC payment system will encourage greater efficiency in ASCs and will promote significant increases in the breadth of surgical procedures performed in ASCs because it distributes payments across the entire spectrum of covered surgical procedures based on a coherent system of relative weights that are related to the clinical and facility resource requirements of those procedures.

The CY 2009 claims data that we used to develop the CY 2011 ASC payment system relative weights and rates reflect the second year of utilization under the revised payment system. Although the changes in the claims data are not large, the data reflect increased Medicare ASC spending for procedures that were newly added to the ASC list in CY 2008. Our estimates based on CY 2009 data indicate that for CY 2011 there will be especially noticeable increases in spending for respiratory systems, and hematologic and lymphatic systems, compared to the previous ASC payment system.

4. Estimated Effects of This Final Rule With Comment Period on Beneficiaries

We estimate that the CY 2011 update to the ASC payment system will be generally positive for beneficiaries with respect to the new procedures that we are adding to the ASC list of covered surgical procedures and for those that we are designating as office-based for CY 2011. First, as discussed in section XV.D.1.d. of this final rule with comment period, we are waiving the coinsurance, the Part B deductible, or both for certain preventive services recommended by the United States Preventive Services Task Force with a grade of A or B for any indication or population and that are appropriate for the individual to comply with sections 4104 and 10406 of the Affordable Care Act. Other than these services, the ASC coinsurance rate for all procedures is 20 percent. This contrasts with procedures performed in HOPDs, where the beneficiary is responsible for copayments that range from 20 percent to 40 percent of the procedure payment. Second, ASC payment rates under the revised payment system are lower than payment rates for the same procedures under the OPPS; therefore, the beneficiary coinsurance amount under the ASC payment system almost always will be less than the OPPS copayment amount for the same services. (The only exceptions will be if the ASC coinsurance amount exceeds the inpatient deductible. The statute requires that copayment amounts under the OPPS not exceed the inpatient deductible.) For new procedures that we are adding to the ASC list of covered surgical procedures in CY 2011, as well as for procedures already included on the list, and that are furnished in an ASC rather than the HOPD setting, the beneficiary coinsurance amount will be less than the OPPS copayment amount. Furthermore, the additions to the ASC list of covered surgical procedures will provide beneficiaries access to more surgical procedures in ASCs. Beneficiary coinsurance for services migrating from physicians' offices to ASCs may decrease or increase under the revised ASC payment system, depending on the particular service and the relative payment amounts for that service in the physician's office compared to the ASC. However, for those additional procedures that we are designating as office-based in CY 2011, the beneficiary coinsurance amount will be no greater than the beneficiary coinsurance in the physician's office.

In addition, as finalized in the August 2, 2007 final rule (72 FR 42521), in CY 2011, the final year of the 4-year transition to the ASC payment rates calculated according to the ASC standard ratesetting methodology of the revised ASC payment system, ASC payment rates for a number of commonly furnished ASC procedures will continue to be reduced, resulting in lower beneficiary coinsurance amounts for these ASC services in CY 2011.

5. Conclusion

The updates to the ASC payment system for CY 2011 will affect each of the approximately 5,000 ASCs currently approved for participation in the Medicare program. The effect on an individual ASC will depend on its mix of patients, the proportion of the ASC's patients that are Medicare beneficiaries, the degree to which the payments for the procedures offered by the ASC are changed under the revised payment system, and the extent to which the ASC provides a different set of procedures in the coming year.

The CY 2011 update to the revised ASC payment system includes an MFP-adjusted CPI–U increase factor of 0.2 percent that we estimate will result in a slightly higher amount of Medicare expenditures in CY 2011 than was estimated to be made in CY 2010. We estimate that the update to the revised ASC payment system, including the addition of surgical procedures to the list of covered surgical procedures, will have minimal effect on Medicare expenditures compared to the estimated level of Medicare expenditures in CY 2010.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table 70 below, we have prepared an accounting statement showing the classification of the expenditures associated with the 0.2 percent update to the CY 2011 revised ASC payment system, based on the provisions of this final rule with comment period and the baseline spending estimates for ASCs in the FY 2011 President's Budget. This table provides our best estimate of Medicare payments to suppliers as a result of the update to the CY 2011 ASC payment system, as presented in this final rule with comment period. All expenditures are classified as transfers.

TABLE 70—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS FROM CY 2010 TO CY 2011 AS A RESULT OF THE CY 2011 UPDATE TO THE REVISED ASC PAYMENT SYSTEM

Category	Transfers
Annualized Monetized Transfers.	$5.9 million.
From Whom to Whom.	Federal Government to Medicare Providers and Suppliers.
Total	$5.9 million.

D. Effect of Requirements for Hospitals' Reporting of Quality Data for Annual Hospital Payment Update

In section XVI. of the CY 2009 OPPS/ASC final rule with comment period (73 FR 68758), we discussed our requirements for subsection (d) hospitals to report quality data under the HOP QDRP in order to receive the full payment update for CY 2010. In section XVI. of the CY 2010 OPPS/ASC final rule with comment period (74 FR 60629), we discussed our requirements for subsection (d) hospitals to report quality data under the HOP QDRP in order to receive the full payment update for CY 2011. In section XVI. of this final rule with comment period, we established additional policies affecting

the HOP QDRP for CY 2012, CY 2013, and CY 2014. We estimate that about 90 hospitals may not receive the full payment update in CY 2011. Most of these hospitals receive little to no OPPS reimbursement on an annual basis. However, at this time, information is not available to determine the precise number of hospitals that do not meet the requirements for the full hospital market basket increase for CY 2011. We also estimate that 90 hospitals may not receive the full payment update in CY 2012. We are unable at this time to estimate the number of hospitals that may not receive the full payment update in CY 2013 and CY 2014.

In section XVI.E.3.a. of the CY 2010 OPPS/ASC final rule with comment period (74 FR 60647 through 60650), for the CY 2011 payment update, as part of the validation process, we are requiring hospitals to submit paper copies of requested medical records to a designated contractor within the required timeframe. Failure to submit requested documentation can result in a 2 percentage point reduction in a hospital's update, but the failure to attain a validation score threshold will not. Of the 90 hospitals that we estimate will not receive the full payment update for CY 2011, we estimate that no more than 20 hospitals will fail the validation documentation submission requirement for the CY 2011 payment update.

In section XVI.E.3.b. of the CY 2010 OPPS/ASC final rule with comment period, we did not, at that time, adopt our proposal in the CY 2010 OPPS/ASC proposed rule (74 FR 60650 through 60652) to expand the CY 2011 validation requirement for the CY 2012 payment update. Instead, we stated that we would consider the public comments we received on that proposal, as well as any analyses we conduct of the CY 2011 validation process, and propose a CY 2012 validation process as a part of the CY 2011 OPPS/ASC rulemaking. We stated that we believed that this approach would give HOP QDRP hospitals experience with the validation process and allow these hospitals sufficient time to prepare for the CY 2012 validation.

In this final rule with comment period, we have finalized our proposal to validate data submitted by 800 hospitals for purposes of the CY 2012 HOP QDRP payment determination. For CY 2011 and under our policy for CY 2012 in this final rule with comment period, we stated that we will conduct a measure level validation (we note, however, that the validation results will not affect the CY 2011 payment update) by assessing whether the measure data submitted by the hospital matches the independently reabstracted measure data. In addition, for the CY 2012 payment update in this final rule with comment period, we have decided to validate data for only 800 hospitals out of the approximately 3,200 HOP QDRP participating hospitals. We believe that this approach is suitable for HOP QDRP data because it will: Produce a more reliable estimate of whether a hospital's submitted data have been abstracted accurately; provide more statistically reliable estimates of the quality of care delivered in each selected hospital as well as at the national level; and reduce overall hospital burden because most hospitals will not be selected to undergo validation each year. We have adopted a threshold of 75 percent as the threshold for the validation score because we believe this level is reasonable for hospitals to achieve while still ensuring accuracy of the data. Additionally, this level is consistent with what we adopted in the Hospital Inpatient Quality Reporting Program (formerly referred to as the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program) (75 FR 50225 through 50229). As a result, we believe that the effect of our validation process for CY 2012 will be minimal in terms of the number of hospitals that will not meet all program requirements.

The validation requirement for CY 2011 of 7,300 requested cases and for CY 2012 of a maximum of 12 cases per hospital per quarter will result in medical record documentation for approximately 7,300 total cases and 9,600 cases per quarter, respectively, being submitted to a designated CMS contractor. We will pay for the cost of sending this medical record documentation to the designated CMS contractor at the rate of 12 cents per page for copying and approximately $1.00 per case for postage. We have found that, based on experience, an outpatient medical chart is up to 10 pages. Thus, as a result of validation requirements effective for the CY 2011 annual payment update and the CY 2012 annual payment update, respectively, we will have expenditures of approximately $8,760 total and $21,120 per quarter. Again, as we will pay for the data collection effort, we believe that a requirement for medical record documentation for 7,300 total cases for CY 2011 and a maximum of 12 cases per quarter for 800 hospitals for CY 2012 represent minimal burden to HOP QDRP-participating hospitals.

E. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this final rule with comment period was reviewed by the Office of Management and Budget.

XXI. Final Rule: Changes Relating to Payments to Hospitals for Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) Costs

A. Background

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) and implemented in regulations at 42 CFR 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved graduate medical education (GME) programs. Section 1886(h)(2) of the Act sets forth a methodology for the determination of a hospital-specific base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable direct costs of GME in a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, October 1, 1983 through September 30, 1984). The base year PRA is updated annually for inflation. In general, Medicare direct GME payments are calculated by multiplying the hospital's updated PRA by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (and nonprovider sites, when applicable), and the hospital's Medicare share of total inpatient days.

Section 1886(d)(5)(B) of the Act provides for an additional payment amount under the hospital inpatient prospective payment system (IPPS) for hospitals that have residents in an approved GME program in order to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at 42 CFR 412.105.

The Balanced Budget Act of 1997 (Pub. L. 105–33) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its FTE resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on

or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997.

The recently enacted Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) made a number of statutory changes relating to the determination of a hospital's FTE resident count for direct GME and IME payment purposes and the manner in which FTE resident limits are calculated and applied to hospitals under certain circumstances. (These two pieces of legislation are collectively referred to in this document as the "Affordable Care Act.") Below we summarize the proposals to implement the provisions of the Affordable Care Act relating to Medicare direct GME and IME payments that were included in the August 3, 2010 proposed rule (75 FR 46383) (as part of the CY 2011 OPPS/ASC proposed rule document), summarize the public comments we received, respond to those public comments, and set forth our final policy.

B. Counting Resident Time in Nonprovider Settings (Section 5504 of the Affordable Care Act)

1. Background and Changes Made by the Affordable Care Act

Effective July 1, 1987, the Social Security Act was amended to allow hospitals to count the time residents spend training in sites that are not part of the hospital (referred to as "nonprovider" or "nonhospital sites") for purposes of direct GME payments under certain conditions. Section 1886(h)(4)(A) of the Act (as added by section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509, also known as (OBRA '86) provides that the Secretary "shall establish rules consistent with this paragraph for the computation of the number of full-time equivalent residents in an approved medical residency training program." Specifically, section 1886(h)(4)(E) of the Act requires that the Secretary's rules concerning the computation of FTE residents for purposes of direct GME payments "provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting" (as added by section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) (OBRA 86)). Regulations implementing this provision were published in the September 29, 1989 final rule (54 FR 40292) at 42 CFR 413.86(f)(3) (now § 413.78(c)), which stated that a hospital may count the time residents spend in nonprovider settings for purposes of direct GME payment if: (1) The residents spend their time in patient care activities; and (2) there is a written agreement between the hospital and the nonprovider entity stating that the hospital will incur all or substantially all of the costs of the program. The regulations at that time defined "all or substantially all" of the costs to include the residents' compensation for the time spent at the nonprovider setting. Under section 1886(h)(4)(E) of the Act, only one single hospital was permitted to incur the costs of a particular training program and count the time residents spend training in a particular nonprovider setting.

Prior to October 1, 1997, for purposes of the IME payment adjustment, hospitals were not permitted to count the time residents spent training in nonprovider settings. However, section 4621(b)(2) of the Balanced Budget Act of 1997 (Pub. L. 105–33) revised section 1886(d)(5)(B) of the Act to allow providers to count time residents spend training in nonprovider sites for IME purposes, effective for discharges occurring on or after October 1, 1997. Specifically, section 1886(d)(5)(B)(iv) of the Act was amended to provide that "all the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a nonprovider setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting." In the July 31, 1998 final rule (63 FR 41005), at § 412.105(f)(1)(ii)(C) and § 413.86(f)(4), we specified the requirements that a hospital must meet in order to include the time spent by residents training in a nonprovider site in its FTE count for purposes of both direct GME and IME payments (we note that § 413.86(f)(4) is now redesignated as § 413.78(d)). In that final rule, we also redefined "all or substantially all of the costs for the training program in the nonprovider setting" as the residents' salaries and fringe benefits (including travel and lodging where applicable), and the portion of the cost of teaching physicians' salaries and fringe benefits that are attributable to GME.

Pursuant to the statutory authority in sections 1815(a), 1861(v)(1)(A), 1886(h)(3)(B), 1886(h)(4)(A), 1886(h)(4)(E), and 1886(k), and in order to implement section 1886(h)(4)(E) (and later, section 1886(d)(5)(B)(iv)) of the Act, and to assist contractors in determining whether a hospital incurred "all or substantially all" of the costs of the program in the nonprovider setting, we required under § 413.86(f)(3) and (f)(4) that there must be a written agreement between the hospital and the nonprovider site stating that the hospital will incur "all or substantially all" of the costs of training in the nonprovider setting (we note that § 413.86(f)(3) and (f)(4) are now redesignated as § 413.78(c) and (d), respectively). We later specified at § 413.78(d)(2) that the written agreement must indicate the amount of compensation provided by the hospital to the nonprovider site for supervisory teaching activities. We have explained the nature of and the rationale for the written agreement requirement and identified the statutory authority for the written agreement in considerable detail in the preamble to other rules (for example, 63 FR 40954, 40986 through 40989, 63 FR 40992 through 40994, and 63 FR 40996 (July 31, 1998); 68 FR 45346 (August 1, 2003); 69 FR 48916, 49179 through 49180 (August 11, 2004); and 72 FR 26870, 26969–26970 (May 11, 2007)). We have referred to this written agreement as a "written contract" (63 FR 40954, 40989 (July 31, 1998)). We have explained that the written agreement requirement was a useful and easily administered documentation requirement, an administrative tool, a payment safeguard which, among other things, allowed the Secretary to identify the costs of offsite training and to determine whether a hospital seeking Medicare reimbursement for the offsite training of residents (or some other entity) had paid all or substantially all costs of the offsite training. Among other things, the written agreement requirement allowed the Secretary to ensure that: (a) Two or more hospitals were not paid for the same costs of offsite training of residents; (b) the hospital seeking Medicare reimbursement for the offsite training of residents was not reimbursed for costs which a nonprovider site really had incurred; and (c) that the hospital seeking Medicare reimbursement for the offsite training of residents and a nonprovider setting were not both paid for costs of offsite training.

Section 713 of the Medicare Prescription Drug, Improvement, and

Modernization Act of 2003 (MMA) imposed a 1-year moratorium relating to certain nonprovider site teaching physician costs for the period from January 1, 2004, through December 31, 2004. During this 1-year period, we were required to allow hospitals to count FTE allopathic or osteopathic family practice residents training in nonprovider settings for IME and direct GME payment purposes without regard to the financial arrangement between the hospital and the teaching physician practicing in the nonprovider setting to which the resident was assigned. We instructed our Medicare contractors (then referred to as only "fiscal intermediaries" or "FIs") regarding the effect of section 713 of the MMA by stating that, when settling prior year cost reports during this 1-year period, or for family practice residents actually training in nonprovider settings during this 1-year period, contractors should allow hospitals to count allopathic and osteopathic family practice residents training in a nonprovider setting for direct GME and IME payment purposes without regard to the financial arrangement between the hospital and the nonprovider site pertaining to the teaching physicians' costs associated with the residency program. For additional information on this provision and for a summary of public comments we received and our responses related to this provision, we refer readers to the FY 2005 IPPS final rule (69 FR 49176, August 11, 2004).

In an effort to build in some flexibility and in an effort to respond to concerns expressed by hospitals about the administrative burden associated with meeting the written agreement requirements, the Secretary revised the written agreement rule to give hospitals more options. Specifically, in the FY 2005 IPPS final rule (69 FR 49179), we revised our regulations at § 413.78(e) to allow hospitals to choose to either enter into a written agreement with the nonprovider site before the hospital may begin to count residents training at the nonprovider site, or to pay concurrently for the cost of training at the nonprovider setting. That is, in the absence of a written agreement, hospitals are required to pay "all or substantially all" of the costs of the training program in the nonprovider setting by the end of the third month following the month in which the training occurs. While the FY 2005 final rule preamble language indicated that the Secretary had concluded that the written agreement was not the only way for the agency to ensure that a given hospital was complying with the statute's "all or substantially all" of the cost requirement, it also indicated that it was and had been a sensible means of doing so (69 FR 48916, 49179, Aug. 11, 2004).

On May 11, 2007, we published changes in the IPPS final rule (72 FR 26949) that once again modified the definition of "all or substantially all of the costs for the training program in the nonprovider setting." That final rule further defined "all or substantially all" under § 413.75(b) to mean at least 90 percent of the total costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of the teaching physician's salaries attributable to GME. Although some public commenters had objected to our proposed redefinition of the "all or substantially all," we adopted the 90 percent rule because we believed it would substantially address concerns that had been voiced previously by the industry. With this modification, hospitals were no longer required to pay 100 percent of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the teaching physicians' costs attributable to GME at the nonprovider site. This change in policy also allowed providers to use an alternative, less burdensome method to calculate the GME teaching physicians' costs attributable to direct GME at nonprovider sites. In addition to the redefinition of "all or substantially all of the costs," the May 11, 2007 final rule modified the regulation text at § 413.78(f)(3)(ii) to clarify that the required written agreement between a hospital and a nonprovider site must be in place before residents begin training at the nonprovider site. That final rule also specified the information that must be included in the written agreement, and stated that the amounts specified in the written agreement may be modified by June 30 of the applicable academic year.

Section 5504(a) of the Affordable Care Act made changes to section 1886(h)(4)(E) of the Act to reduce the costs that hospitals must incur for residents training in nonprovider sites in order to count the FTE residents for purposes of Medicare direct GME payments. Specifically, section 5504(a) amended the statute to allow a hospital to count all the time that a resident trains in activities related to patient care in a nonprovider site so long as the hospital incurs the costs of the residents' salaries and fringe benefits for the time that the resident spends training in the nonprovider site. Section 5504(b) of the Affordable Care Act made similar changes to section 1886(d)(5)(B)(iv) of the Act for IME payment purposes. For direct GME payments, the provision is effective for cost reporting periods beginning on or after July 1, 2010; for IME payments, the provision is effective for discharges occurring on or after July 1, 2010. The changes made by section 5504(a) and (b) of the Affordable Care Act also specify that if more than one hospital incurs the residency training costs in a nonprovider setting, those hospitals are to count a proportional share of the training time as determined by written agreement between the hospitals. In addition, section 5504(a) amended section 1886(h)(4)(E) of the Act to require hospitals to maintain documents indicating the amount of time the residents they are claiming spend training in nonprovider sites relative to a base year that the Secretary will specify, and to make those documents available to the Secretary.

Section 5504(c) of the Affordable Care Act specifies that the amendments made by the provisions of sections 5504(a) and (b) shall not be applied in a manner that would require the reopening of settled cost reports, for which there is not a jurisdictionally proper appeal pending on the issue of direct GME or IME payments as of March 23, 2010 (the date of the enactment of Pub. L. 111–148). In the August 3, 2010 proposed rule (75 FR 46385), we proposed to interpret "pending, jurisdictionally proper appeal on direct GME or IME payments" to mean that in order for a hospital to request a change to its FTE count, for direct GME or IME, the "pending, jurisdictionally proper appeal" must be specific to direct GME or IME, respectively.

Comment: One commenter asked that CMS clarify the definition of a nonprovider site. The commenter specifically asked whether the term "nonprovider site" would apply to a situation in which residents in a family practice program rotate to a physician's office but accompany the doctor to a separate, nonteaching hospital. Another commenter requested that CMS clarify the definitions of nonprovider and hospital-based settings to state that hospital-based settings can include a variety of ambulatory experiences.

Response: A "nonprovider site" is a setting that does not qualify as a provider-based facility or organization in accordance with the criteria in the regulations at 42 CFR 413.65. In addition, the regulations at 42 CFR 413.78(b) state that "a hospital cannot claim the time spent by residents at another hospital." Therefore, in the example given by the first commenter,

the hospital where the resident usually trains in his or her family practice program cannot count the time that the resident spends rotating with a physician to another hospital. We do not believe that the regulations need to be revised to include a separate definition of a "nonprovider site" as it applies to this provision.

Comment: Many commenters disagreed with our interpretation of the application provisions of section 5504(c) of the Affordable Care Act. The commenters believed that the statute clearly allows hospitals to reopen cost reports that have a jurisdictionally proper pending appeal as of March 23, 2010, regardless of whether or not the issue under appeal is specifically related to direct GME or IME payments. Because many of the GME provisions in the Affordable Care Act apply retroactively (for example, the provisions regarding didactic time in section 5505), the commenters believed that CMS should not place additional restrictions on a hospital's ability to appeal. Another commenter suggested that CMS allow providers to reopen cost reports for an Affordable Care Act issue on direct GME or IME as long as the hospital has a jurisdictionally proper appeal pending for either an IME or direct GME issue.

Another commenter stated that it generally considers an IME appeal issue to be specific to the aspect of IME that the provider is contesting. Therefore, the commenter suggested that an allowable appeal under section 5504 be limited to appeals in which the provider contests issues covered by section 5504, and not direct GME or IME on an overall basis.

One commenter asked whether the provisions of section 5504 could be applied to open cost reports for which no Notice of Program Reimbursement (NPR) has been issued, and which, therefore, does not have any jurisdictionally proper appeals pending.

Another commenter claimed that the application provisions of section 5504(c) clearly apply the provisions of sections 5504(a) and (b) to cost reporting periods occurring before July 1, 2011 [sic]. The commenter asserted that because section 5504(c) expressly states that the provisions of this section "shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending" as of March 23, 2010, such nonprovider site training time should be allowed for those cost reports, even though the provisions of sections 5504(a) are only effective as of July 1, 2010.

Response: There appears to be a misreading of our interpretation of section 5504(c). The effective date of the provisions of section 5504 is clearly July 1, 2010. This date is unambiguously stated in the plain text of section 5504(a), which states that it is "effective for cost reporting periods beginning on or after July 1, 2010." Similarly, section 5504(b) is "effective for discharges occurring on or after July 1, 2010." Our discussion of section 5504(c) in the August 3, 2010 proposed rule (75 FR 46385) only intended to explain our interpretation of the phrase "a jurisdictionally proper appeal pending" in the context of the plain language of the statute. However, we are clarifying in this final rule that, as noted above, and unlike some other provisions of the Affordable Care Act, section 5504 is fully prospective, with an explicit effective date of July 1, 2010, for the new standards it creates. Nothing in section 5504(c) overrides that effective date. Section 5504(c) merely notes that the usual discretionary authority of Medicare contractors to reopen cost reports is not changed by the provisions of section 5504; it simply makes clear that Medicare contractors are not required by reason of section 5504 to reopen any settled cost report as to which a provider does not have a jurisdictionally proper appeal pending. It does not require reopening in any circumstance; and the new substantive standard is, in any event, explicitly prospective. We believe if Congress had wanted to require such action or to apply the new standards to cost years or discharges prior to July 1, 2010, it would have done so in far more explicit terms.

2. Elimination of the "All or Substantially All of the Costs for the Training Program in the Nonprovider Setting" Requirement and New Cost Requirements for Hospitals

As stated earlier, in the May 11, 2007 final rule (72 FR 26949), we redefined the phrase "all or substantially all of the costs for the training program in the nonprovider setting" under § 413.75(b) of the regulations to mean at least 90 percent of the total costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of the teaching physicians' salaries attributable to nonpatient care direct GME. However, section 5504 of the Affordable Care Act revised the Act, effective on July 1, 2010, and eliminated the requirement that a hospital incur "all or substantially all of the costs for the training program in the nonprovider setting." Under the changes made by section 5504, hospitals are only required to incur the costs of the resident's salaries and fringe benefits during the time the resident spends in the nonprovider setting, and they no longer have to incur other training costs in the nonprovider site in order to count such time for direct GME and IME purposes.

In the August 3, 2010 proposed rule (75 FR 46385), we proposed to revise the regulation at § 413.75(b) accordingly to conform to these new statutory requirements. Specifically, we proposed to revise the existing definition of "all or substantially all of the costs for the training program in the nonprovider setting" to be effective for cost reporting periods beginning on or after July 1, 2007, and before July 1, 2010. We also proposed to add a new § 413.78(g) that details how hospitals should count residents that train in nonprovider sites for cost reporting periods beginning on or after July 1, 2010. Specifically, we proposed to require under § 413.78(g)(2) that a hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting in order to count that time for direct GME payment purposes. We also proposed to revise § 412.105(f) to reflect these changes for the purposes of IME payments.

Comment: Many commenters supported the proposed changes to the regulations to reflect the provisions of section 5504 of the Affordable Care Act. Some commenters remarked that these changes vastly simplify the recordkeeping required of hospitals to follow the regulations, which will allow hospitals to focus on providing quality care and medical education. Similarly, other commenters noted that the proposed regulations removed hospitals' administrative burden of calculating teaching physician costs at nonprovider sites. The commenters also applauded the proposed changes because they reflect encouragement of resident training in nonprovider settings.

Response: We appreciate this positive feedback from commenters.

Comment: One commenter stated that it is clear that the revisions to the existing definition of "all or substantially all of the costs for the training program in the nonprovider setting" would be applicable to cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, but that it is not clear how years prior to July 1, 2007 should be handled. The commenter maintained that the Medicare contractors should be instructed to apply these rules to all open cost report years.

Response: The proposed changes to the definition of "all or substantially all of the costs for the training program in the nonprovider setting" are effective for cost reporting periods beginning on or after July 1, 2010 for direct GME and for discharges occurring on or after July 1, 2010 for IME. We did not propose any changes to the definition of "all or substantially all of the costs for the training program in the nonprovider setting" for cost reporting periods beginning before July 1, 2010 or for discharges occurring before July 1, 2010. Medicare contractors will continue to treat nonprovider site training time prior to July 1, 2010 as they were required to under the regulations in effect prior to July 1, 2010.

After consideration of the public comments we received, we are finalizing our proposed changes to the regulations at § 413.75(b), § 413.78(f)(1), § 413.78(g), and § 412.105(f)(1)(iii) regarding new cost requirement for hospitals without modification.

3. Revision to Regulations To Allow More Than One Hospital To Incur the Costs of Training Programs at Nonprovider Settings, Either Directly or Through a Third Party

As indicated above, prior to the enactment of the Affordable Care Act, section 1886(h)(4)(E) of the Act (regarding direct GME) and section 1886(d)(5)(B)(iv) of the Act (regarding IME) allowed a hospital to count the time spent by residents training in a nonprovider site only when one single hospital incurred the costs of a particular training program in a particular nonprovider setting. We note that both sections of the statute specified that a hospital could count the time spent by residents training in a nonprovider site "if *the hospital* incurs all or substantially all of the costs for the training program in *that* setting" (emphasis added). While we understand that, in some cases, hospitals share the costs of training residents in a specific program at the same nonprovider site, we have historically only allowed one hospital to count time spent by those residents at a nonprovider site if that single hospital met the requirement to incur "all or substantially all" of the training program costs at the nonprovider site. Accordingly, two or more hospitals could not count the time spent by residents in a specific program training at a nonprovider site if they shared the training costs at the site or if a third party incurred the costs of training at a nonprovider site on behalf of several hospitals. Examples of third parties that might incur nonprovider site training program costs are a medical or dental school, or a GME administrative entity that is established to operate the GME program.

Sections 5504(a) and (b) of the Affordable Care Act specifically address the situation in which more than one hospital incurs the costs of training programs at nonprovider settings, either directly or through a third party. Sections 5504(a) and (b) amended sections 1886(h)(4)(E) and 1886(d)(5)(B)(iv) of the Act, respectively, to provide that when more than one hospital incur these costs, either directly or through a third party, those hospitals "shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting." Therefore, these statutory changes now allow hospitals to share the costs of resident training at nonprovider sites, so long as those hospitals divide the resident time proportionally in accordance with a written agreement, for the purposes of determining their respective direct GME and IME FTE resident counts at the nonprovider site. These provisions of the statute are effective for cost reporting periods beginning on or after July 1, 2010, for direct GME, and for discharges occurring on or after July 1, 2010, for IME. Accordingly, although hospitals that shared training costs at nonprovider sites could not count any of resident time spent training at those nonprovider sites prior to July 1, 2010, hospitals can count that training time beginning on or after July 1, 2010, as long as they divide the resident training time proportionally and record that proportion in a written agreement.

In the August 3, 2010 proposed rule (75 FR 46385 through 46387), we proposed to revise our regulations to reflect the statutory provision that allows hospitals to proportionally share the costs of resident training at nonprovider sites under a new paragraph (g)(2) of § 413.78 for direct GME and to make a conforming cross-reference change under § 412.105(f)(1)(ii)(E) of the IME regulations. While the statute allows hospitals to determine by a written agreement the proportional share of time that residents spend training in the nonprovider site, we proposed that hospitals must use a reasonable basis for establishing that proportion (proposed § 413.78(g)(2)(ii), final § 413.78(g)(2)(i)). One such reasonable basis could be that each hospital counts the number of FTEs for which it incurs the salaries and fringe benefits. For example, if there are 10 FTEs training in a nonprovider setting in a particular program, and there are 2 hospitals that each incur the costs of the salaries and fringe benefits of 5 of those FTEs, each hospital could agree to count 50 percent of the FTEs (even if each hospital is not necessarily paying 50 percent of the cost, due to differences in resident salary amounts, this arrangement is acceptable, so long as 100 percent of the required cost is paid).

In addition to having a reasonable basis for establishing the proportion, hospitals must be able to document the amount that they are paying, and this amount must equate to *at least* the sum of all the salaries and fringe benefits of the residents for the amount of time that the residents are training in that site. The salaries and fringe benefits of the residents will vary depending upon the program year of the residents, and the specialty in which they are training. As we indicated in the May 11, 2007 final rule (72 FR 26961), hospitals must "take into account the actual salary and fringe benefits for each FTE resident that trains in the nonprovider site, which may vary by resident." Therefore, as also indicated in the May 11, 2007 final rule (72 FR 26970), global agreements that cover a variety of issues (GME and non-GME) between the hospital(s) and the nonprovider site, and that only specify a lump sum payment amount with no break out of the residents' salaries and fringe benefits, do not provide sufficient information for the Medicare contractor to determine that "all or substantially all" of the costs (or, effective July 1, 2010, that all of the residents' salaries and fringe benefits) have been paid by the hospitals. Accordingly, we would expect that, regardless of whether there is one hospital paying the cost, or more than one hospital is sharing the costs, hospitals would need to determine prior to the start of nonprovider rotations (with allowance for modification by June 30 of that academic year) the total cost of the salaries and fringe benefits of the residents that are training for the proportion of the year spent in each nonprovider site. Of course, in the instance where the residents remain on the payroll of one or more hospitals for the entire year, it would be easier to document that the hospital(s) continues to pay the residents' salaries and fringe benefits when the residents rotate to nonprovider sites. Similarly, where the residents are on the payroll of the medical or dental school, or of a third party GME administrative entity, and the hospitals reimburse the school or the third party for the *entire* salary and fringe benefit costs of the residents, for both hospital and nonprovider training, the hospitals could easily document that

they have incurred the requisite costs of training in nonprovider sites. However, once the total costs for the residents' salaries and fringe benefits for time spent in the nonprovider site are determined and covered by the hospitals, the hospitals may decide among themselves the proportion of those costs each will incur, and may use a reasonable basis to allocate among themselves the proportion of FTE residents that each one will count, as discussed above.

As specified in section 5504 of the Affordable Care Act, in the August 3, 2010 proposed rule (75 FR 46386), we proposed that hospitals must record the proportion of the FTE resident time spent training in the nonprovider site that will be counted by each hospital for purposes of IME and direct GME payment, as well as the reasonable basis for the proportion, in a written agreement between the hospitals. We proposed to add this requirement in regulations at § 413.78(g)(2). If hospitals have in place written agreements with the nonprovider site in accordance with our existing regulations at § 413.78(f)(3)(ii), we proposed that the proportion of the FTE resident training time to be counted for IME and direct GME purposes by each hospital, and the basis for the proportion, may be recorded in that agreement (proposed § 413.78(g)(2)(iii)). We proposed that if the hospitals choose to pay the training program costs concurrently as described in § 413.78(g)(3)(i), that is, without a written agreement, the hospitals must still agree in writing to the proportion of costs and training time they plan to incur and count (proposed § 413.78(g)(2)(iv), final § 413.78(g)(2)(iii)) in addition to the basis for that proportion, before the end of the applicable training year. That written agreement between the hospitals must be available for CMS review and for auditing purposes. In addition, we indicated that we would expect that the hospitals' records of resident training time and training costs at nonprovider sites, as required by the Affordable Care Act and as discussed below, reflect the proportions of training time and costs as agreed upon and documented in whichever type of written agreement the hospitals used to record the proportional shares of resident training time that each will count for purposes of direct GME and IME payment.

Comment: One commenter supported the proposed changes regarding allowing hospitals to share the costs of training residents at nonprovider sites.

Response: We appreciate the commenter's support.

Comment: Several commenters requested that CMS detail the documentation requirements in cases where a third party incurs the costs of training at a nonprovider site on behalf of several hospitals, where hospitals have a global agreement with that third party, and when a hospital pays a nonprovider site concurrently. Many commenters stated that they did not believe that resident compensation costs must be itemized in order for a hospital to receive the Medicare payments to which it is entitled.

A large number of these commenters noted that hospitals that pay residents salaries and fringe benefits through global agreements and that do not use an invoice system to track costs, may find it "unduly burdensome" to change their internal accounting practices in order to produce the proper documentation to comply with this proposed regulation. Some of those commenters suggested that, instead, a "memorandum of understanding" between a hospital and a third party be sufficient for documentation of the sharing of costs between the two entities. They suggested that this memorandum would be effective at the beginning of a hospital's fiscal year, and it would project the expected amount of resident compensation for the year. Further, they suggested that the memorandum would be followed by a year-end reconciliation of costs. The commenters concluded by stating that all hospitals would benefit from clear instructions regarding these documentation requirements. Other commenters suggested that CMS clarify that as long as the hospital provides documentation that "(1) it is compensating the third-party an amount that is at least equal to the aggregate of the salary and fringes for the resident full-time equivalents (FTEs) training at a nonprovider site, and (2) the amount paid to the third-party is identified in the global agreement as being for that purpose," this documentation would be sufficient for the hospital to demonstrate that it is incurring the costs of training those resident FTEs at the nonprovider setting. Another commenter believed that identifying the FTE count at nonprovider sites should be sufficient for these documentation requirements. Other commenters suggested that as long as all of the hospitals that share the residents' time are funding 100 percent of the resident stipends and benefits in the aggregate, and they are not claiming more than 100 percent of the residents' time, CMS permit hospitals to determine for themselves when and how to allocate resident time spent in nonprovider sites.

Response: In order to effectively implement and ensure compliance with section 5504, we must require that the written agreement between a hospital and a third party that incurs the costs of training at a nonprovider site contain information that clearly documents that the hospital is incurring the costs of the residents' salaries and fringe benefits at each nonprovider site. If the third party that pays the residents' salaries and fringe benefits also owns some or all of the nonprovider sites to which the residents rotate, one master agreement with the third party is sufficient, so long as the number of FTEs and dollar amount for total costs incurred for those FTEs is specified in the master agreement for each program at each nonprovider site.

Similar documentation requirements exist in situations in which two hospitals share the costs of training residents at a nonprovider site. If two hospitals share the costs of training residents in a given program at the same nonprovider site, the hospitals must be able to document together that they paid the salaries and fringe benefits of all the residents in that program for the time spent training at that nonprovider site, and they also must explain in a written agreement the arrangement for dividing the costs and FTEs. For each nonprovider site in which the hospital wishes to claim the FTEs for IME and direct GME, a hospital must include in the written agreement (or document, if it is paying concurrently)—

(1) The *total* number of FTE residents in *each* program at *each* nonprovider site (if the hospital is sharing the costs of the residents' salaries and fringe benefits with another hospital(s), each hospital would specify the number of FTEs in each program at each site for which they are paying the salaries and fringe benefits); and

(2) The total dollar amount the hospital is paying for all those FTE residents at each nonprovider site respectively. The hospital need not list the program years and the individual salaries and benefits for each FTE in each program year for each program, but the hospital would be expected to supply such information at audit so that the Medicare contractor could replicate how the hospital arrived at the total dollar amount included in the written agreement (and paid by the hospital). In addition, the hospital must include all this information regardless of whether the agreement is directly between it and the nonprovider site, or if the agreement involves a third party.

Comment: Several commenters contended that it is impractical and burdensome to require hospitals to identify the costs of training residents at nonprovider sites prior to the start of nonprovider site rotations on July 1 of an academic year. One commenter maintained that such costs can only be calculated after June 30 of an academic year. The commenter explained that because residents rotating at nonprovider sites often retain some responsibilities at a hospital, and that those residents' rotations between both sites varies from day to day, an accounting of nonprovider site training time must occur retrospectively.

Response: We believe that hospitals should have a general sense of the salary and fringe benefit costs of the residents that will be training at nonprovider sites before the start of an academic year. Salary and fringe benefit costs for each specialty and program year are usually fixed before the start of an academic year, and the only variable that could reasonably change after the start of resident rotations would be the exact number of FTEs rotating to nonprovider sites. If residents' rotation assignments are governed by program directors at the medical school and not by the hospital itself, the hospital should be able to retrieve this information from the medical school.

Written agreements can be amended by the end of the academic year on June 30 to account for such rotation changes, as specified in the new § 413.78(g)(3)(ii). Hospitals also can opt to pay nonprovider sites concurrently according to the new § 413.78(g)(2)(iii), in which case no written agreement regarding the payment of resident salaries and fringe benefits is required. (We note that in a case where multiple hospitals pay the nonprovider site concurrently, a written agreement is still required to document the reasonable basis upon which those multiple hospitals divide the payment of resident salaries and fringe benefits to the nonprovider site.)

Comment: A number of commenters encouraged CMS to clearly state that section 5504 not only allows hospitals that share the cost of nonprovider site training to "*count a proportional share of the time*" of that training, but that it also allows hospitals to adjust their direct GME and IME caps accordingly.

Other commenters noted that hospitals that already train above their cap would have no incentive to increase their residents' nonprovider site training under this provision because they would not be able to claim the additional time if the total count of nonprovider site training time is less than the amount the hospital is over its cap.

A number of commenters who generally addressed the current system of Medicare GME payment called for reforms in the system and advocated targeted, if not wholesale, lifting of the FTE caps. However, the commenters noted that such measures would require Congressional legislation, and they acknowledged that CMS cannot implement such changes through rulemaking. Rather, the commenters encouraged CMS to work with Congress toward lifting the cap as soon as possible.

Response: We appreciate the comments on the Medicare GME payment system in general. With regard to the request for cap increases under the provisions of section 5504, hospitals cannot adjust their caps to reflect the additional FTE time that is allowable under section 5504. Rather, a hospital is permitted to count that additional FTE time within the limits of its direct GME and IME caps. While hospitals that already train over their respective FTE caps may not have a clear financial incentive to increase nonprovider site training time under this provision, the easing of other nonprovider training requirements under section 5504 can still facilitate an increase in nonprovider site training from those hospitals.

Comment: Some commenters requested that CMS refrain from disallowing resident time spent in shared nonprovider site rotations prior to July 1, 2010. The commenters claimed that disallowing resident training time in nonprovider settings harms our national health interests and violates the spirit of the Affordable Care Act. The commenters believed that CMS has the authority to refrain from enforcing its previous policy on counting shared nonprovider site training time.

Response: The statute does not provide CMS discretion to allow the counting of resident time spent in shared nonprovider site rotations for cost reporting periods beginning prior to July 1, 2010. Section 5504 explicitly provides that a hospital may count shared nonprovider site rotation time to cost reporting periods beginning on or after July 1, 2010, for direct GME, and for discharges occurring on or after July 1, 2010, for IME, if a hospital incurs certain costs.

After consideration of the public comments we received, we are finalizing our proposed revisions of the regulations at §§ 413.78(g)(2) and (g)(3) to allow more than one hospital to incur the costs of nonprovider site training programs, either directly or through a third party.

4. Changes to Regulations Regarding Recordkeeping and Comparison to a Base Year

As stated above, section 5504(a) of the Affordable Care Act requires hospitals to maintain records of the amount of time that the residents they are claiming spend in nonprovider settings, and to compare that time to the time spent by the residents in nonprovider sites in a base year as the Secretary may specify. This requirement is effective for cost reporting periods beginning on or after July 1, 2010. In the August 3, 2010 proposed rule (75 FR 46387), we proposed to incorporate this statutory requirement for maintaining records under a new paragraph (g)(5) of § 413.78 of the regulations. We also stated that we anticipated amending the cost report for hospitals to include lines where hospitals can submit the required data, which is described below. These data will help CMS identify whether barriers to resident training in nonprovider sites exist. The original allowance of IME payments for training in nonprovider sites, as instituted by the BBA, was intended to act as an incentive to hospitals to increase such training. However, we have not seen a marked increase in the amount of training that occurs in nonprovider settings in the years since the implementation of the BBA. Advocates of expanding training in nonprovider sites have alleged that CMS' rules for counting residents in nonprovider sites regarding teaching physician salary costs were an obstacle to the expansion of training in nonprovider settings. The recordkeeping and reporting requirement added by section 5504(a) of the Affordable Care Act will provide the Secretary information to assess whether nonprovider site resident training increases as a result of the statutory revision of rules that were viewed as burdensome.

We understand that rotation schedules are a primary source of information that hospitals supply to Medicare contractors for determining where and for how much time each resident spends training in each hospital or nonprovider site. Therefore, in the August 3, 2010 proposed rule (75 FR 46387), we proposed that rotation schedules be the source for establishing the amount of time that residents spend training in nonprovider sites, both in the base year and in subsequent years. The amendment to section 1886(h)(4)(E) of the Act by section 5504(a) of the Affordable Care Act states that the Secretary shall specify the

aforementioned base year for the level of training at nonprovider sites. We proposed that cost reporting periods beginning on or after July 1, 2009 and before June 30, 2010 be the base year against which we will compare subsequent years' data to determine if the level of nonprovider training that occurs in subsequent years increases relative to that base year (proposed new § 413.78(g)(5)).

Section 5504(a) of the Affordable Care Act also made changes to require that these records be made available to the Secretary. In order for CMS to evaluate whether nonprovider site training has increased as a result of the changes made by section 5504 of the Affordable Care Act, in the August 3, 2010 proposed rule (75 FR 46387), we proposed to include several additional cost report lines for hospitals to submit data for each of their primary care programs on a program-specific basis. With respect to hospitals' nonprimary care programs, hospitals would only need to supply that data on an overall hospital basis, and we proposed to add one line on the cost report for hospitals to submit that data. We proposed to only require program-specific data with respect to resident training time in nonprovider sites for primary care specialties because we believe that that is sufficient for the intent of this provision. The intent of this recordkeeping requirement is to see whether, as a result of the policy changes required under section 5504(a) of the Affordable Care Act, there is an increase in the volume of residency training that takes place in nonprovider settings. Because residents at nonprovider sites typically train in primary care specialties, and in order to minimize the documentation burden on hospitals, we stated that we did not believe it is necessary to require program-specific data for other specialties that would provide only marginally useful information. For the purposes of this provision, we proposed to use the definition of primary care resident in § 413.75(b) to identify those programs for which we proposed to require program-specific data.

Once this information is made available to CMS, the data would be compared to the analogous data from the base year of cost reporting periods beginning on or after July 1, 2009 and before June 30, 2010 to determine whether the volume of nonprovider site training has increased. Specifically, we proposed to use the total unweighted direct GME count of FTE training time in a primary care specialty in nonprovider sites (prior to application of direct GME FTE resident limits) as the gauge to determine if residency training time in nonprovider settings in that specialty has increased in an academic year relative to the base year. Therefore, we proposed that hospitals would only be required to submit the respective unweighted direct GME FTE counts on the new cost report lines for each primary care specialty and for nonprimary care specialties on an overall basis. For example, if, in the base year, we find that 3.75 direct GME FTEs out of a total of 15 FTE family practice residents from a family practice residency program in a teaching hospital trained in nonprovider settings (that is, 25 percent of the FTE time of the residents in the family practice residency program was spent training in nonprovider sites), we would note the subsequent years' amount of direct GME FTE training time in nonprovider sites in that particular teaching program to see if that FTE proportion increased from 25 percent. This would help determine if more training time is spent by primary care residents in nonprovider sites. Or, for all of the nonprimary care teaching programs in a hospital, if 100 direct GME FTE residents out of 400 FTE residents spent time training in nonprovider settings (that is, 25 percent of the time spent by residents in the nonprimary care programs is spent training in nonprovider sites), we would look to see if, in subsequent years, more than 25 percent of the time spent by nonprimary care direct GME FTEs from that hospital is spent training in nonprovider sites.

Comment: One commenter recommended that CMS specify that the primary sources of information that hospitals supply to Medicare contractors for determining where and for how much time each resident spends training in each hospital or nonprovider site include not only rotation schedules, but also "other similar documentation normally maintained by the hospital," because some hospitals use alternative standards for documenting resident rotations to nonprovider sites.

Response: The rotation schedules prepared by the program directors are the primary source of information regarding the residents' assignments because they contain a snapshot of each resident's rotations to multiple sites (that is, different hospitals as well as nonprovider sites). Therefore, this information often allows the Medicare contractors to determine whether more than one hospital is including the same rotation in its GME and/or IME FTE count. In rare and extenuating circumstances where the rotation schedules are not available, the hospital should upon request, furnish the Medicare contractor with similar documentation that is official (that is, is based on the approval of the program director), that is similar for all hospitals to which the residents in the program rotate, and that is auditable. We note that such alternative documentation must be contemporaneous to the academic year in which the rotations occur.

Comment: Several commenters remarked that the data that CMS proposed to collect under the recordkeeping requirement of section 5504 will not provide a full and complete portrayal of the amount of time that residents spend training in nonprovider sites. The commenters gave numerous possible reasons for a decrease in a hospital's nonprovider setting training time from year to year that would not be related to a hospital's GME policy decisions. Those reasons include a greater or lesser ability of the hospitals to match residents into a particular program and residents' leaves of absence within a particular program. The commenters also explained that ambulatory care training can occur in provider-based settings, VA hospitals, and military clinics, in addition to nonprovider sites, but according to the proposed recordkeeping requirements, such time would not be included in the data either. The commenters requested that CMS enumerate the limitations of the data that will be collected under this statutory requirement, so that the public and other policymakers understand why the amount of nonprovider site training for a particular hospital may vary from one year to the next.

Response: Section 5504 requires CMS to collect the nonprovider site training data that is affected under this provision. We do not agree that the data that we are requesting for the purposes of this provision naturally fluctuates, even if residents leave training programs for reasons that bear little or no connection to a hospital's GME policy decisions. The data we are collecting will determine the percentage of time spent in nonprovider site training. We will analyze the data in order to determine whether CMS' former rules regarding teaching physician salary costs for counting residents in nonprovider sites were truly an obstacle to the expansion of training in nonprovider settings, as was claimed by advocates of such expanded training. We also remind providers that the use and evaluation of this data collection will have no direct implications for Medicare GME payments.

Comment: Numerous commenters believed that the proposal to add lines to the cost report for the purposes of this

recordkeeping requirement was an added administrative burden to hospitals, as was the proposal to require such cost report data on a program-by-program basis for primary care specialties. The commenters claimed that the statute merely requires hospitals to "maintain and make available to the Secretary" records on resident training time in nonprovider sites, and the proposed regulations greatly complicated this requirement. The commenters believed that the intent of section 5504 was to simplify the already burdensome resident reporting requirements on hospitals.

Some commenters suggested that CMS instead interpret section 5504 as only requiring hospitals to have these records and make them available on an as-needed basis. The commenters noted that, if CMS decides to finalize the policy to add lines to the cost report for the purposes of this section 5504 requirement, CMS limit the additional lines to two: one line for primary care data and one line for nonprimary data.

Response: We believe that the addition of a few cost report lines for the purposes of this recordkeeping requirement does not pose an undue burden on hospitals. The data that we are requesting are already collected by hospitals for other GME purposes, and hospitals should not experience an added burden from the requirement to enter that information in the cost report. The Affordable Care Act gave CMS explicit authority to require that this recordkeeping data be maintained and made available, and the most direct method of making such data available to Medicare contractors is by reporting it on the Medicare cost report. Therefore, we are finalizing this policy as proposed.

Comment: One commenter suggested that CMS change the base year that it will use to determine if nonprovider site rotations are increasing to cost reporting periods beginning on or after July 1, 2010 and before June 30, 2011. The commenter stated that providers who are currently unable to claim time spent at nonprovider settings, due to the administrative requirements in place now, would not be claiming them on the cost report until the 2010–2011 academic year. Therefore, the commenter stated, an analysis of nonprovider site training time using the current proposed base year would indicate a greater increase in such rotations than might actually exist.

Response: We chose the base year of cost reporting periods beginning on or after July 1, 2009 and before June 30, 2010 because it is the last year before the effective date of the provisions of section 5504. Accordingly, we believe that the base year that we proposed will best serve our goal of determining whether nonprovider site training actually increased as a result of the provisions of section 5504. Therefore, we are finalizing the base year as proposed.

Comment: One commenter expressed support for the proposal to track resident training time in nonprovider sites and requested that CMS clearly report the findings of its analysis of the nonprovider site training data. The commenter also requested that CMS enumerate the various factors that influence training in nonprovider sites when it reports the findings.

Response: The statute does not require CMS to report any findings that result from this data collection. Therefore, we are not currently planning to officially report any such findings.

Comment: Some commenters requested that CMS change the definition of primary care to replace the outdated term "osteopathic general practice" with the term "traditional rotating internship" at section 1886(h)(5)(H) of the Act.

Response: We do not have the authority to change the statutory definition of "primary care resident" at section 1886(h)(5)(H) of the Act.

After consideration of the public comments we received, we are finalizing our changes to the regulations at § 413.78(g)(5) regarding recordkeeping and comparison to a base year as proposed.

C. Counting Resident Time for Didactic and Scholarly Activities and Other Activities (Section 5505 of the Affordable Care Act)

1. Background and Changes Made by the Affordable Care Act

Prior to the enactment of the Affordable Care Act, only the time that residents spent training at a nonprovider setting in patient care activities, as part of an approved program, could be included in a hospital's direct GME or IME FTE resident count. There were also differences in the rules for counting FTE resident time during the time that residents spend training in the hospital for direct GME and IME payments. For direct GME payment purposes, under 42 CFR 413.78(a), "residents in an approved program working in all areas of the hospital complex may be counted." As explained in the September 29, 1989 **Federal Register** (54 FR 40286), the hospital complex consists of the hospital and the hospital-based providers and subproviders. Therefore, a hospital need not distinguish between patient care activities and nonpatient care activities when determining its direct GME count when the residents are training in the hospital complex. However, for IME payment purposes, consistent with the regulations at 42 CFR 413.9 and 412.105(f)(1)(ii) only time spent in patient care activities in the portion of the hospital subject to the hospital inpatient prospective payment system and the outpatient department of a hospital is counted. As stated in the FY 2002 IPPS final rule, it has been our longstanding policy that, regardless of the site of training, "we do not include residents in the IME count to the extent that the residents are not involved in furnishing patient care" (66 FR 39897). Thus, in the FY 2002 final rule, CMS reiterated its policy that resident research time not associated with the diagnosis or treatment of a particular patient could not be included in the IME FTE count (66 FR 39897). In the FY 2007 final rule, CMS clarified that this exclusion also applied to all nonpatient care activities, such as didactic conferences and seminars (71 FR 48040).

Section 5505(a) of the Affordable Care Act added new subparagraph (J) to section 1886(h)(4) (as amended by section 5504) of the Act to allow hospitals to count certain nonpatient care activities that occur in certain nonprovider settings, including didactic conferences and seminars, in the hospital's direct GME FTE resident counts. The provision added by section 5505(a) allows a hospital to count the time that residents spend training in an approved program in a "nonprovider setting that is primarily engaged in furnishing patient care" for direct GME purposes, even if those residents are engaged in nonpatient care activities, such as didactic conferences and seminars (but not including research not associated with the treatment or diagnosis of a particular patient), during that training time at the nonprovider site. This statutory change is effective for cost reporting periods beginning on or after July 1, 2009. In the August 3, 2010 proposed rule (75 FR 46388), we proposed to revise our regulations at § 413.78(f)(1) and (g)(1) to reflect the statutory provision.

Section 5505(b) of the Affordable Care Act addressed IME and added a new clause (x) to section 1886(d)(5)(B) of the Act which allows certain nonpatient care activities, including didactic conferences and seminars (but not including research not associated with the treatment or diagnosis of a particular patient), to be counted for IME purposes

as well. However, for IME purposes, this change only applies to such activities during training that occurs in subsection (d) hospitals (which are IPPS hospitals), subsection (d) Puerto Rico hospitals (IPPS hospitals in Puerto Rico), hospitals that are reimbursed under a reimbursement system authorized under section 1814(b)(3) of the Act, or provider-based hospital outpatient departments. The IME provision is applicable to cost reporting periods beginning on or after January 1, 1983. In the August 3, 2010 proposed rule (75 FR 46388), we proposed to revise our regulations at § 412.105(f)(1)(ii)(A) through (f)(1)(ii)(D) and (f)(1)(iii)(C) to reflect these statutory provisions.

As specified in section 1886(d)(5)(B)(x)(III) of the Act, as added by section 5505(b) of the Affordable Care Act, research activities that are not associated with the treatment or diagnosis of a particular patient are excluded from the allowable IME count of FTE residents, and this specific change applies to cost reporting periods beginning on or after October 1, 2001. Section 5505(c) of the Affordable Care Act provides that section 1886(d)(5)(B)(x)(III) of the Act shall not give rise to any inference as to how the law in effect prior to October 1, 2001, should be interpreted. We discuss these provisions and our proposed and final implementation under section XXI.C.3. of this preamble.

Section 10501(j) of Public Law 111–148 amended section 5505 to clarify its application. The amendment prohibits the provisions of section 5505 from being applied in a manner that would require the reopening of settled cost reports except where the provider has a jurisdictionally proper appeal pending on the issue of direct GME or IME payments as of March 23, 2010 (the date of the enactment of Pub. L. 111–148). In the August 3, 2010 proposed rule (75 FR 46388), we proposed to reflect this provision in the proposed revisions to our regulations under § 412.105(f)(1)(ii), § 412.105(f)(1)(iii)(C), and § 413.78(h). We also proposed, as mentioned in section XXI.B.1. of this preamble with respect to section 5504 of the Affordable Care Act, to interpret "jurisdictionally proper appeal pending" on direct GME or IME payments for this section to mean that, in order for a hospital to request a change to its FTE count, direct GME or IME respectively, the "jurisdictionally proper appeal pending" must be specific to direct GME or IME respectively. For example, in order for a hospital to increase its FTE count with regard to a provision of the Affordable Care Act that is unique to IME (such as inclusion in the IME count of didactic time occurring in the hospital as specified by new section 1886(d)(5)(B)(x)(II)) of the Act, the hospital's "jurisdictionally proper appeal pending" must be on an IME issue related to IME FTEs or the available bed count. However, if the hospital's "jurisdictionally proper appeal pending" is on an issue that only affects direct GME payments, such as the initial residency period or the Medicare patient load, that appeal would not be sufficient in order for the hospital to increase its FTE count with regard to a provision of the Affordable Care Act that is unique to IME, such as didactic time in the hospital setting.

Comment: Several commenters provided a general statement on their belief that the Medicare program is intended to support all resident training time. The commenters explained that direct patient care, research activities, and educational and didactic activities all comprise one "seamless educational experience" of physician resident training. The commenters believed that Congress did not intend for this fluid training to be "parsed" by CMS.

Response: We disagree with the commenters' assertions regarding Congressional intent to fund resident training. The Conference Report that accompanied the Social Security Amendments of 1965, Public Law 89–97 (S. Rept. No. 404, 89th Cong., 1st Sess. 36 (1965); H.R. No. 213, 89th Cong., 1st Sess. 32 (1965)) shows that Congress intended for Medicare GME funding to be limited in scope and temporary in its duration. The Conference Report also indicates that Medicare GME funding was only intended to assist hospitals in resident training, and not to fully fund such training. Finally, we note that much of the "parsing" of resident training time into allowable and nonallowable time was mandated by Congress, and as such, CMS does not have discretion to allow all resident training time to count for Medicare GME payment purposes.

Comment: Many commenters disagreed with our interpretation of the application provision of section 5505(d) of the Affordable Care Act. The commenters believed that the statute clearly allows hospitals to reopen cost reports that have a jurisdictionally proper pending appeal as of March 23, 2010, regardless of whether or not the issue under appeal is specifically related to direct GME or IME payments. Because many of the provisions of section 5505 apply retroactively, the commenters believed that CMS should not place additional restrictions on a hospital's ability to request reopenings of cost reports. The commenters also believed that hospitals with cost reports for which the hospitals retained a right to timely file a jurisdictionally proper appeal as of March 23, 2010 should be allowed to reopen such cost reports, whether or not the appeal was pending by that date.

Another commenter requested that CMS clarify certain issues surrounding the application of section 5505. The commenter asked how providers will be paid for previous disallowances of didactic time for IME purposes, now that section 5505 allows hospitals to count such time retroactively since January 1, 1983, if most relevant cost reports cannot be reopened under the application of section 5505. The commenter also asked if administrative and judicial decisions that disallowed IME didactic time can be reversed.

Another commenter requested that CMS clarify the cost reporting periods to which section 5505 applies. The commenter explained that providers have 180 days to appeal a Notice of Program Reimbursement (NPR), and, therefore, hospitals that received a final determination on their cost reports after September 24, 2009 would not be permitted to appeal or reopen a cost report for didactic time for the purposes of section 5505. The commenter believed that CMS should allow hospitals that have not received their initial NPR as of September 24, 2009 to reopen or appeal their respective cost reports.

Response: Section 5505(d) of the Affordable Care Act explicitly states that the amendments of that section need not be applied to settled cost reports, unless there is a jurisdictionally proper appeal pending on that cost report on certain direct GME or IME issues. We do not have the authority to expand the scope of section 5505(d) to pending appeals on other issues, and we are retaining our interpretation of the term "jurisdictionally proper appeal pending" in the context of section 5505(d) to mean that the appeal must be specific to direct GME or IME respectively. We believe that the intent of section 5505 as a whole was to change GME policy for the future, and that the intent of section 5505(d) specifically was to limit the number of cost report adjustments, and not to encourage a mass reopening of cost reports. The cost report reopening process is one that is very costly and time-consuming for CMS and its contractors, and it is disruptive to the efficient operation of the Medicare program. Therefore, we interpreted section 5505(d) in the spirit of the section as a whole, to be only applicable in those limited circumstances where there is a "jurisdictionally proper appeal

pending" on a cost report specific to direct GME or IME respectively.

2. Definition of "Nonprovider Setting That Is Primarily Engaged in Furnishing Patient Care"

As stated above, section 5505(a) of the Affordable Care Act amended section 1886(h)(4) of the Act to allow a hospital to count the time that residents spend in certain didactic nonpatient care activities in nonprovider sites towards the hospital's direct GME resident count for cost reporting periods beginning on or after July 1, 2009. Section 5505(a)(2) defines the term "nonprovider setting that is primarily engaged in furnishing patient care" to mean "a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary." In past discussions regarding our policy to disallow time spent by residents in didactic nonpatient care activities, we have provided extensive explanations of what is meant by the term "patient care activities." When section 1886(h)(4)(E) of the Act was first implemented, we specifically stated that "only time spent in activities relating to patient care may be counted [in nonprovider sites]" (54 FR 40292, September 29, 1989). In 1998, when we implemented the statute allowing FTE residents to be counted in nonprovider sites for IME, we reiterated that a hospital may only count resident training time "in nonprovider sites for indirect and direct GME, respectively, if the resident is involved in patient care" (63 FR 40986, July 31, 1998). In addition, we note that the scope of the term "patient care" had been well-established in the Medicare program even prior to issuance of the first rules on counting FTE residents for purposes of direct GME and IME payments. For example, prior to the IPPS, acute care hospitals were paid by Medicare for inpatient services based on their reasonable operating costs, or costs relating to the provision of reasonable and necessary "patient care." The longstanding regulation at 42 CFR 413.9 (Costs related to patient care) specifies that Medicare payment is limited to those services relating to "patient care," or to those directly related to covered services for the care of beneficiaries. In the August 18, 2006 **Federal Register,** we defined the term "patient care activities" at 42 CFR 413.75(b) in a way that was consistent with these previous, plain-language applications of the term as "the care and treatment of particular patients, including services for which a physician or other practitioner may bill, and orientation activities as defined in this section" (71 FR 48142).

Section 5505(a) of the Affordable Care Act added a new subparagraph (K) to section 1886(h)(5) of the Act which defines the term "nonprovider setting that is primarily engaged in furnishing patient care" to mean "a nonprovider setting in which the primary activity is the care and treatment of particular patients, as defined by the Secretary." This definition uses the term "patient care" which we have defined previously, as discussed above. In the August 3, 2010 proposed rule (75 FR 46388 and 46389), we proposed to continue applying our current definition of the term "patient care" as described above and in current regulations and other guidance. Examples of nonprovider settings that would be "primarily engaged in furnishing patient care" are those settings in which the main mission is to provide patient care, such as doctors' offices and community health clinics. Nonprovider settings that *would not* meet these criteria include those with a main mission other than patient care. An example of a nonprovider setting that does not meet the "primarily engaged in furnishing patient care" criterion set forth in this section would be a hotel or convention center. While residents may attend didactic conferences and seminars in a hotel or convention center, that didactic time cannot be counted toward a hospital's direct GME FTE count because the main mission of a hotel or convention center is the provision of hospitality and meeting services. Thus, any such time spent in a hotel or convention center would not occur in a setting that is primarily engaged in furnishing patient care. Another example of such settings is a medical school and dental school, even if those schools are part of a larger system that includes institutions that are primarily engaged in patient care. Despite any affiliations with patient care settings, medical and dental schools are institutions that are primarily engaged in educational activities as opposed to patient care. Medical and dental schools retain their principal mission of education regardless of their participation in various systems and affiliations, parts of which may involve settings that are primarily engaged in furnishing patient care.

The exclusion of medical and dental schools from the definition of "nonprovider setting that is primarily engaged in furnishing patient care" is consistent with longstanding CMS policy, and we have addressed this policy several times in the past. We explained in response to comments in the aforementioned August 18, 2006 **Federal Register** that, "[W]e understand that it is quite common for hospitals, especially large academic medical centers, to be located on the same campus as a medical school, where the buildings are very closely situated or even connected, and the facilities are often shared. However * * * hospitals, nonprovider sites, and medical schools are structured separately for legal and financial purposes, and are recognized independently for state licensing and Medicare cost reporting purposes." As we stated in the FY 2007 final rule, "to put it simply, a hospital is not a medical school, and a medical school is not a hospital" (71 FR 48093). In the August 22, 2007 **Federal Register,** we clarified that, "[T]he commenter is also correct that orientation activities in a related medical school cannot be counted * * * the nonprovider settings we were referring to in which orientation may be counted are those nonprovider settings such as physicians' offices or clinics, where patient care is routinely provided and a hospital is permitted to count the time spent by residents in accordance with our regulations at §§ 412.105(f)(1)(ii)(C) and 413.78(f), *not* other nonprovider settings where time spent by residents is not permitted to be counted for purposes of direct GME and IME" (72 FR 47382). Thus, while time spent by residents in certain nonpatient care activities may be counted for direct GME payment purposes in a nonprovider site primarily engaged in furnishing patient care, time spent by residents in nonpatient care activities at nonprovider sites that are not primarily engaged in patient care activities is not allowable for direct GME and IME payment purposes.

In the August 3, 2010 proposed rule (75 FR 46389), we proposed to add, under § 413.75(b), the statutory definition of "nonprovider setting that is primarily engaged in furnishing patient care" to the definition of general terms used throughout the GME regulations.

Comment: A number of commenters requested that CMS adopt a one workday payment policy threshold for didactic time as it relates to resident training in the nonprovider setting. The commenters indicated that this threshold would allow a hospital to count a full day of resident training, so long as the resident engaged in some patient care during the day (that is, the entire day of training did not consist of didactic training time). The commenters believed that this suggested policy change would ease and simplify hospitals' administrative burdens. The commenter suggested that if CMS is not willing to adopt this policy threshold, CMS at least confirm that its current one

workday administrative rule, which is a documentation policy and not a payment policy, continues to apply for IME purposes to didactic training in nonprovider settings.

Response: We believe that, with section 5505, Congress has spoken definitively regarding didactic time. Prior to the enactment of the Affordable Care Act, our strict reading of the statute regarding "patient care" led us to deny counting didactic training for IME in the hospital settings and to deny counting didactic time for both direct GME and IME in the nonprovider setting. As such, we adopted the one workday rule as an administrative expediency policy for hospitals that wished to simplify documentation practices. However, now that Congress has specifically allowed all didactic training in the hospital for IME, and even allowed didactic training time in a nonprovider site that is "primarily engaged in furnishing patient care" to be counted for direct GME, we believe that generally, most didactic training in GME programs will now be allowable under the provisions of section 5505. Accordingly, we believe it is appropriate to strictly apply the statutory criteria and no longer allow hospitals to apply a one workday administrative rule. Therefore, we are clarifying in this final rule that the one workday administrative rule regarding didactic training time will no longer be permitted for IME or direct GME documentation and counting of time beginning with portions of cost reporting periods beginning on or after January 1, 2011.

Comment: Many commenters suggested that CMS include dental clinics within the definition of a "nonprovider setting that is primarily engaged in providing patient care." The commenters explained that dental schools frequently train dental residents in patient-care clinics that are located on the dental school premises. The commenters pointed out that this is in contrast to medical schools, which do not typically operate medical clinics. As such, the commenters claimed that "dental residency programs are singled out by CMS' proposed interpretation in a way that medical residency programs are not." The commenters maintained that because the "main mission" of dental clinics is clearly to provide patient care, the time that a dental resident spends in a clinic, including any time the residents spends in didactic training in the clinic, should be counted for DGME payment purposes.

Another commenter requested that, in addition to dental school clinics, CMS include physician offices housed within medical schools and homes of patients in its definition of "a nonprovider setting that is primarily engaged in furnishing patient care."

Another commenter asked if a nonteaching hospital could be considered "a nonprovider setting that is primarily engaged in furnishing patient care."

Response: We agree with the commenters who requested that we consider dental school clinics to be a "nonprovider setting that is primarily engaged in furnishing patient care." In the proposed definition at § 413.75(b), we defined "nonprovider setting that is primarily engaged in furnishing patient care" as "a nonprovider setting in which the primary activity is the care and treatment of patients." We agree that dental and medical clinics fit that proposed criterion. Therefore, we are amending our proposed policy to include both dental and medical school patient care clinics in the category of a "nonprovider setting that is primarily engaged in furnishing patient care," as long as the hospital clearly documents that any such didactic activities occurred in the clinics proper, and not in another location on the school campus. For example, a didactic activity that occurs in a conference room that is clearly located within the clinic may be counted, but if the same activity occurs elsewhere on the school campus that is outside the clinic, the time may not be counted.

A physician's office is also considered a "nonprovider setting that is primarily engaged in furnishing patient care." Homes of patients are obviously not settings that are primarily engaged in furnishing patient care, and nonteaching hospitals are not considered "nonprovider settings" at all because they are, by definition, providers. Furthermore, the regulations at § 413.78(b) state that a hospital cannot claim the time spent by residents training at another hospital. We are not expanding our definition of "nonprovider setting that is primarily engaged in furnishing patient care" to any other additional settings in this final rule.

After consideration of the public comments we received, we are finalizing our proposed definition of "nonprovider setting that is primarily engaged in furnishing patient care," at § 413.75(b), but we are amending our proposed policy to include dental and medical school clinics under that definition, as discussed above.

Comment: One commenter asked about a case in which a resident is transferred to train at another hospital, and which hospital should claim that FTE time in such a case.

Response: This comment is out of scope of the provisions of the proposed rule and is not relevant to the GME changes of the Affordable Care Act that are being implemented. Therefore, we are not addressing it in this final rule.

3. Distinguishing Between Allowed "Nonpatient Care Activities" and Nonallowable Research Time

As discussed above, research time that is not associated with the treatment or diagnosis of a particular patient is specifically excluded from the "nonpatient care activities, such as didactic conferences and seminars" that are otherwise allowable under section 5505 of the Affordable Care Act. There are several unique features of "research not associated with the treatment or diagnosis of a particular patient" that distinguish it from "nonpatient care activities, such as didactic conferences and seminars." From the outset of the Medicare program, research costs have not been considered reasonable costs of patient care, unless the research is associated with the treatment or diagnosis of a particular patient. (S. Rept. No. 89–404, Part I, p. 36 (June 30, 1965) ("Identifiable expenses for medical research * * * over and above the costs closely related to normal patient care, would not be met from the trust fund.")); 31 FR 14814, Nov. 22, 1966 (promulgating prior version of 42 CFR 413.90(a)).

"Research not associated with the treatment or diagnosis of a particular patient" usually comprises activities that are focused on developing new medical treatments, evaluating medical treatments for efficacy or safety, or elaborating upon knowledge that will contribute to the development and evaluation of new medical treatments in the future, rather than on establishing a diagnosis or furnishing therapeutic services for a particular patient.

Section 5505 of the Affordable Care Act further distinguishes "research not associated with the treatment or diagnosis of a particular patient" from "nonpatient care activities, such as didactic conferences and seminars," by specifying that nonpatient care activities include "didactic conferences and seminars," but not research that is not associated with the treatment or diagnosis of a particular patient. Conferences or seminars could include an administrative rotation, which would include resident training in the administrative aspects of medical care such as practice management.

Comment: Many commenters believed that the definition of "research not associated with the treatment or diagnosis of a particular patient" was

too broad. Specifically, several commenters remarked that the inclusion of "evaluating medical treatments for efficacy or safety" appeared to include quality and safety projects, which the commenters believed to be essential to train a new generation of physicians who prioritize quality and safety in patient care. The commenters requested that CMS clarify that resident time spent on quality and safety projects is countable as didactic time. One commenter specifically suggested that CMS revise the definition of research to be "activities whose sole purpose is the development of new medical treatment for use in the future."

Several commenters also requested that CMS adopt a one workday payment policy threshold for research time. Similar to the same commenters' request above for a one workday threshold for didactic time, the commenters requested that if CMS would not be willing to adopt the one workday threshold suggestion, CMS adopt a one workday administrative rule for research time, which is a documentation policy and not a payment policy. The commenters were of the opinion that consistency between the policies for both didactic and research time is critical for reducing hospitals' administrative burden and preventing confusion between the two policies.

Response: We are not revising our proposed definition of "research not associated with the treatment or diagnosis of a particular patient" at this time, nor are we expanding our proposed policy on research time to allow for a one workday threshold. Moreover, we are not establishing an administrative rule for documenting resident time spent in such research activities. We believe that our proposed definition of the term encompasses the activities that Congress excluded from the allowed "nonpatient care activities" of section 5505. We believe that, with section 5505, Congress has spoken definitively regarding research time. In section 5505, Congress clearly excluded counting any research time for IME purposes and research time at nonprovider sites for direct GME purposes, unless it is associated with the treatment or diagnosis of a particular patient. As such, we believe it is appropriate to exclude even a partial day of "research not associated with the treatment or diagnosis of a particular patient" from the determination of the number of FTEs for GME payment purposes. A one workday rule would effectively allow the hospital to count nonallowable research time in its FTE counts. In addition, as we explained in response to a comment above, the one workday administrative rule is no longer permitted for didactic time either, for portions of cost reporting periods beginning on or after January 1, 2011.

Comment: One commenter stated that, in the proposed rule, CMS did not include a regulation regarding the October 1, 2001 effective date for the exclusion of "research activities that are not associated with the treatment or diagnosis of a particular patient" for IME payment purposes. The commenter noted that the statute clearly stated the October 1, 2001 effective date of the provision, and that the statute clarified that "such section, as so added, shall not give rise to any inference as to how the law in effect prior to such date should be interpreted." The commenter then remarked that when CMS referred in the proposed rule to section 5505's allowance of didactic activities for IME purposes (75 FR 46387), which CMS noted as excluding such research, CMS referred simultaneously to two policies with effective dates that spanned almost 20 years. The commenter requested that CMS revise the regulations to include the October 1, 2001 effective date of the exclusion of such research, and to treat the two policies regarding didactic time and research time as two distinct and separate policies.

Response: The existing regulations regarding the exclusion of research for IME merely reiterate longstanding policy, as we explained in the August 1, 2001 final rule (66 FR 39896) and, therefore, that the regulation at 42 CFR 412.105(f)(1)(iii)(B) does not have an effective date. We did not include the October 1, 2001 effective date of the exclusion of research time for IME payment purposes in our proposed regulations for the same reason. Congress specified the date we reiterated in our policy by regulation as an effective date for the statutory exclusion of research time for IME. However, Congress did not state that research activities prior to October 1, 2001, are allowed. Rather, Congress deferred to the Secretary to interpret and implement policy regarding research time for IME payment purposes prior to October 1, 2001. This is the meaning of the statement in section 5505 that is quoted by the commenter, that "such section, as so added, shall not give rise to any inference as to how the law in effect prior to such date should be interpreted." This language further means that, subject to the limitations of section 5505(d), in the instances where providers disagree with the Secretary's interpretation of research policy in cost reports prior to October 1, 2001, and the providers appeal research time that was disallowed from their IME FTE counts in those cost reports, the matter would be reserved for adjudication in the courts.

However, there has been some confusion regarding the application of this provision of the Affordable Care Act. Some individuals, and one court decision, have interpreted section 5505(b)'s allowance of nonpatient care activities for IME as of January 1, 1983 to include research time as well. We believe that this interpretation is contrary to the express intent of the statute, which clearly distinguishes "research activities that are not associated with the treatment or diagnosis of a particular patient" from "nonpatient care activities, such as didactic conferences and seminars," and which unmistakably excludes research time. In addition, as explained above, Congress clearly provided that the October 1, 2001 effective date "shall not give rise to any inference" as to how any research time prior to that effective date should be counted for IME. Several other commenters on the proposed rule shared CMS' understanding of section 5505(c) within their comments. These commenters acknowledged that "the law *does not opine* on the status of IME research time prior to October 1, 2001, stating that research provision of the law 'shall not give rise to any inference as to how the law in effect prior to such date should be interpreted'" (emphasis added). This widespread understanding of section 5505(c) aligns with CMS' understanding of this Affordable Care Act language, and is consistent with our view that the Secretary has the authority to interpret section 1886(d)(5)(B) of the Act, as amended by section 5505, and implement policy regarding the time spent in research activities prior to October 1, 2001, as the Secretary determines appropriate.

For all these reasons, we are exercising our authority to define the term "nonpatient care activities," as used in section 5505(b) of the ACA, to adopt proposed § 412.105(f)(1)(iii)(C), which excludes research activities not related to the treatment or diagnosis of a particular patient from the category of allowable "nonpatient care activities." Instead, such research activities would continue to be excluded under § 412.105(f)(1)(iii)(B). In addition to the language and structure of section 5505, as discussed above, we believe such a decision is also supported by important differences between these research activities and the types of nonpatient care activities, for example, didactic conferences and seminars, enumerated in section 5505. For example, interns and residents are often assigned to

blocks of research time, whereas didactic conferences and seminars may occur during periods when an intern or resident is otherwise assigned to a rotation primarily requiring the provision of patient care. In addition, such didactic conferences and seminars may involve presentations or discussions related to the treatment of current patients. It has been our consistent policy to exclude research activities, as we clarified in rulemaking in 2001. We also engaged in rulemaking in 2006 to clarify that didactic time would also not be counted for GME and IME purposes. Set against this background, we read section 5505 as reflecting Congress' clear intent to reverse our 2006 policy regarding didactic time and to ratify our policy regarding research time from October 1, 2001, forward, while also indicating that it was not directing any result as to research activities before October 1, 2001.

After consideration of the public comments we received, we are adopting revised § 412.105(f)(1)(iii)(C) of the regulations to include allowed didactic activities for IME purposes, as proposed without modification. "Research activities that are not associated with the treatment or diagnosis of a particular patient" continue to be excluded under § 412.105(f)(1)(iii)(B).

4. Approved Leaves of Absence

In the FY 2008 IPPS proposed rule (72 FR 24814), we proposed to remove vacation, sick leave and other types of leave from the FTE calculation for IME and for direct GME purposes. We proposed this policy based on our belief that such leave time involved neither patient care nor nonpatient care activities. However, we did not finalize this proposed policy after many public commenters explained that the implementation of the policy would involve significant administrative burdens (FY 2008 IPPS final rule, 72 FR 47374). Instead, our previously existing policy, which allowed vacation and sick leave generally to be counted for direct GME and IME purposes, remained in effect. In the FY 2008 IPPS proposed rule, we also proposed to continue to count the time spent by residents in orientation activities in both the hospital and nonprovider settings. We proposed this policy because we recognized the distinct character of orientation activities as essential to the provision of patient care by residents. We did finalize our policy on orientation time, and in doing so, we specified that patient care activities means the care and treatment of particular patients, including services for which a physician or other practitioner may bill, and orientation activities (§ 413.75(b)), effective for cost reporting periods beginning on or after October 1, 2007.

Section 5505(a) of the Affordable Care Act added new subparagraph (K) to section 1886(h)(4) of the Act to clarify that hospitals may count residents' vacation, sick leave, and other approved leave time toward the hospitals' direct GME FTE resident count, so long as the leave does not prolong the total time the resident participates in his or her approved program. This direct GME provision regarding leave time is effective for cost reporting periods beginning on or after January 1, 1983. In addition, section 5505(b) of the Affordable Care Act added section 1886(d)(5)(B)(x)(I) to the Act, which allows hospitals to count residents' vacation, sick leave, and other approved leave time toward the hospitals' IME FTE resident count, as long as the leave does not prolong the total time the resident participates in his or her approved program. This IME provision regarding leave time is effective for cost reporting periods beginning on or after January 1, 1983.

In the August 3, 2010 proposed rule (75 FR 46389 and 46390), we proposed to revise our regulations to reflect these statutory changes regarding counting residents' vacation, sick leave, and other approved leave time toward the hospitals' direct FTE resident count under new § 413.78(h) for GME and under § 412.105(f)(1)(iii)(D) for IME. We noted that when a resident on leave is training at two hospitals, each hospital is to count the proportion of the leave of absence time as specified in the August 22, 2007 final rule (72 FR 47382). In that rule, we explained that regardless of which hospital is paying the resident's salaries and fringe benefits, the hospital to which the resident is assigned during the time the vacation is taken is the hospital that counts that FTE time for direct GME and IME. If the rotation schedule does not clearly indicate where the resident is assigned during the time the vacation is taken, the hospitals to which the resident rotates over the course of the academic year would divide and count the resident's vacation time proportionately based on the amount of time spent in actual training at the respective hospitals. In the August 3, 2010 proposed rule, we also proposed to specify that "other approved leave" includes those types of generally accepted leave of short duration (those that do not prolong the total time that the resident is participating in the approved training program) that have not been included in our resident leave time policies in the past. Examples of such "other approved leave" could include jury duty, other court leave, or voting leave.

Comment: Numerous commenters objected to the instructions regarding allocating resident vacation time when a resident's rotation schedule does not clearly indicate the resident's assignment during the vacation time. The commenters claimed that hospitals had never been given such strict instructions regarding the allocation of resident vacation time, and the methods used by hospitals to allocate such time among themselves have worked well up until this point. The commenters requested that if CMS is not willing to grant hospitals the discretion to allocate resident vacation time on their own, hospitals should at least be permitted to choose the period over which they divide the time, so long as the period is used consistently.

Response: The instructions given above regarding allocating resident vacation time is a statement of existing policy that we finalized in the FY 2008 final rule (72 FR 47382). We note that this policy only applies in a situation where a resident's rotation schedule does not clearly indicate the resident's assignment during the vacation time. The above instructions are necessary in a case where rotation schedules are unclear as to which hospital a resident is assigned to at any given time. We also note that we have observed a number of hospitals successfully using the method we described to divide resident training time.

Comment: One commenter requested that CMS clarify the definition of "other approved leave," specifically to address whether time away for education that is part of a benefit package would be considered "other approved leave."

Response: In the proposed rule, we explained "other approved leave" as those types of generally accepted leave of short duration (those that do not prolong the total time that the resident is participating in the approved training program) that have not been included in our resident leave time policies in the past. We stated that examples of such "other approved leave" could include jury duty, other court leave, or voting leave. In general, "other approved leave" refers to leave that is taken for personal or administrative reasons, and not leave related to a resident's school or training program.

After consideration of the public comments we received, we are finalizing our proposed policies regarding approved leaves of absences,

as reflected in the regulation at §§ 412.105(f)(1)(iii)(D) and 413.78(h).

D. Reductions and Increases to Hospitals' FTE Resident Caps for GME Payment Purposes (§§ 412.105(f)(1)(iv) and 413.79(m) and (o))

1. General Background on Methodology for Determining the FTE Resident Count

As we discuss in section XXI.A. of this preamble, Medicare makes both direct and indirect GME payments to hospitals that train residents in approved medical residency training programs. Direct GME payments are made in accordance with section 1886(h) of the Act, based generally on hospital-specific PRAs, the number of FTE residents, and the hospital's Medicare patient share. IME payments are made in accordance with section 1886(d)(5)(B) of the Act, based generally on the ratio of the hospital's FTE residents to the number of hospital beds applied to the DRG payments. Accordingly, the calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count; generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. In an attempt to end the implicit incentive for hospitals to increase the number of FTE residents, Congress instituted a cap on the number of allopathic and osteopathic residents a hospital is allowed to count for direct GME and IME purposes under the provisions of section 1886(h)(4)(F) of the Act for direct GME and section 1886(d)(5)(B)(v) of the Act for IME. Dental and podiatric residents are not included in this statutorily mandated cap.

2. Reduction of Hospitals' FTE Resident Caps Under the Provisions of Section 5503 of the Affordable Care Act

Some hospitals have trained a number of allopathic and osteopathic residents in excess of their FTE resident caps. Other hospitals have reduced their FTE resident counts to some level below their FTE resident caps. Section 5503 of the Affordable Care Act added a new section 1886(h)(8) to the Act to provide for reductions in the statutory FTE resident caps for direct GME under Medicare for certain hospitals, and authorizes a "redistribution" to hospitals of the estimated number of FTE resident slots resulting from the reductions. Section 5503 also amended section 1886(d)(5)(B)(v) of the Act to require application of the provisions of 1886(h)(8) "in the same manner" to the FTE resident caps for IME. A previous redistribution of "unused" FTE resident slots was performed under section 422 of Public Law 108–173 (the MMA). Section 422 provided for the redistribution of unused residency positions effective for portions of cost reporting periods beginning on or after July 1, 2005. While the redistribution under section 5503 of the Affordable Care Act is similar to section 422 of Public Law 108–173, there are substantive differences between the two provisions.

The new section 1886(h)(8)(A) of the Act provides that, effective for portions of cost reporting periods occurring on or after July 1, 2011, a hospital's FTE resident cap will be reduced if its "reference resident level" is less than its "otherwise applicable resident limit," as these terms are described below. We note that when we refer to "otherwise applicable resident cap" and "otherwise applicable FTE resident cap" in the regulations, we are using these phrases interchangeably with the statutory term "otherwise applicable resident limit." Use of the phrases "otherwise applicable resident cap" and "otherwise applicable FTE resident cap" is consistent with our reference to a hospital's "limit" as its "cap." Rural hospitals with fewer than 250 acute care inpatient beds as well as those hospitals described in section XXI.D.4. of this preamble are exempt from a reduction. For other hospitals, any such reduction will be equal to 65 percent of the difference between the hospital's "otherwise applicable resident limit" and its "reference resident level."

Under the new section 1886(h)(8)(B) of the Act, the Secretary is authorized to increase the FTE resident caps for certain categories of hospitals for portions of cost reporting periods occurring on or after July 1, 2011, by an aggregate number that does not exceed the estimated overall reduction in FTE resident caps for all hospitals under section 1886(h)(8)(A) of the Act. A single hospital may receive an increase in its FTE resident cap of no more than 75 additional FTEs. That is, a hospital would be allowed to receive up to 75 additional slots for direct GME and up to 75 additional slots for IME. In determining which hospitals would receive an increase in their FTE resident caps, sections 1886(h)(8)(B) through 1886(h)(8)(E) of the Act directs us to—

- Take into account the demonstrated likelihood of the hospital filling the additional positions within the first three cost reporting periods beginning on or after July 1, 2011.
- Take into account whether the hospital has an accredited rural training track program.
- Distribute 70 percent of the resident slots to hospitals located in States with resident-to-population ratios in the lowest quartile.
- Distribute 30 percent of the resident slots to hospitals located in a State, a territory of the United States, or the District of Columbia that are among the top 10 States, territories, or Districts in terms of the ratio of the total population living in an area designated as a health professional shortage area (HSPA), as of March 23, 2010, to the total population, and/or to hospitals located in rural areas.

In summary, section 5503 of the Affordable Care Act added a new section 1886(h)(8) of the Act that prescribes a methodology for determining reductions to certain hospitals' FTE resident caps based on unused FTE resident slots, provides for certain exceptions to the FTE resident cap reductions, and includes general criteria that CMS must consider in making a "redistribution" to other hospitals of the estimated number of FTE resident slots resulting from the reductions in the FTE resident caps. In the August 3, 2010 proposed rule (75 FR 46391 through 46410), we proposed procedures for determining whether, and by what amount, a hospital's FTE resident cap is subject to a reduction under section 1886(h)(8)(A) of the Act. We also specified an application process for hospitals that seek to receive increases in their FTE resident caps and the specific criteria that we will use to determine which hospitals will receive increases in their FTE resident caps under section 1886(h)(8)(B) of the Act.

3. Hospitals Subject to the FTE Resident Cap Reduction

As indicated earlier, section 1886(h)(8)(A) of the Act, as added by section 5503 of the Affordable Care Act, provides that if a hospital's "reference resident level" is less than its "otherwise applicable resident limit," its FTE resident cap(s) will be reduced by 65 percent of the difference between its "otherwise applicable resident limit" and its "reference resident level." Under section 1886(h)(8)(H)(i) of the Act (as added by section 5503 of the Affordable Care Act), the "reference resident level" refers to the number of unweighted allopathic and osteopathic FTE residents who are training at a hospital in a given cost reporting period. That is, the "reference resident level" refers to a hospital's allopathic and osteopathic FTE resident count for a specific period. Under section 1886(h)(8)(H)(ii) the "otherwise applicable resident limit" refers to a hospital's FTE resident cap established under sections

1886(h)(4)(F)(i) and (h)(4)(H) of the Act for direct GME payment purposes and a hospital's resident cap established under section 1886(d)(5)(B)(v) for IME payment purposes. For most hospitals, the permanent FTE cap under section 1886(h)(4)(F)(i) of the Act is based on: (1) For an urban hospital, the number of unweighted allopathic and osteopathic FTE residents in the hospital's most recent cost reporting period ending on or before December 31, 1996 (the "1996 cap"); (2) for a rural hospital, 130 percent of the 1996 cap, adjusted as specified under existing § 413.79(c)(2); and (3) any adjustments to the hospital's cap under paragraph (7), which specifies the previous "redistribution" of resident positions required by section 422 of Public Law 108–173. Section 1886(h)(4)(H) of the Act specifies that a hospital's FTE resident cap under subparagraph (F) may be adjusted for a new medical residency training program established on or after January 1, 1995, participation in a Medicare GME affiliated group, and establishment by an urban hospital of a separately accredited rural training track program. In the August 3, 2010 proposed rule (75 FR46391), we proposed that, in defining a hospital's "otherwise applicable resident limit" for purposes of section 1886(h)(8)(A) of the Act, we will look at the hospital's 1996 cap during its reference year, as adjusted for the following criteria: New programs as defined at § 413.79(e); participation in a Medicare GME affiliation agreement as defined at §§ 413.75(b) and 413.79(f); participation in an emergency Medicare GME affiliation agreement as defined at § 413.79(f); participation in a hospital merger; and whether an urban hospital has a separately accredited rural training track program as defined at § 413.79(k). We discuss the applicability of Medicare GME affiliation agreements under section 1886(h)(8)(A) of the Act in more detail under section XXI.D.8.c. of this preamble and the treatment of hospital mergers under section XXI.D.8.d. of this preamble. Furthermore, section 1886(h)(8)(H)(iii) of the Act requires that, in determining a hospital's "otherwise applicable resident limit," section 1886(h)(7)(A) of the Act shall be taken into account. Section 1886(h)(7)(A) of the Act refers to the reduction to a hospital's cap(s) under section 422 of Public Law 108–173. The application of section 422 of Public Law 108–173 to the implementation of section 5503 of the Affordable Care Act is further discussed under section XXI.D.10. of this preamble.

In our discussion of the provisions of section 5503 of the Affordable Care Act under this section, we generally refer to a hospital's number of unweighted allopathic and osteopathic FTE residents in a particular period as a hospital's "resident level." We also refer to a hospital's resident level in the applicable "reference period," as explained further below, as the hospital's "reference resident level." In addition, we refer to the "otherwise applicable resident limit" as the hospital's FTE resident cap that is applicable during the relevant cost reporting period. Thus, in the August 3, 2010 proposed rule (75 FR 46391), we proposed that, effective for portions of cost reporting periods beginning on or after July 1, 2011, we would permanently reduce the hospital's FTE resident cap by 65 percent of the difference between the reference resident level and the hospital's otherwise applicable resident limit for IME and direct GME, respectively. For example, if a hospital's otherwise applicable resident limit for the reference period is 100, and its reference resident level is 80 FTEs, we would reduce the hospital's FTE resident cap by 13 FTEs (0.65*[100—80)] = 13). We proposed to add new regulations at § 412.105(f)(1)(iv)(B)(*2*) for IME and at § 413.79(m) for direct GME to reflect our proposals regarding reductions to hospitals' FTE resident caps under section 5503 of the Affordable Care Act.

Comment: One commenter requested that emergency Medicare GME affiliation agreements be disregarded for purposes of determining a hospital's otherwise applicable resident limit. The commenter agreed with CMS' proposed policy to consider Medicare GME affiliation agreements when determining a hospital's otherwise applicable resident limit, but stated that emergency Medicare GME affiliation agreements are distinctly different from regular Medicare GME affiliation agreements because the purpose of emergency Medicare GME affiliation agreements is to minimize the disruption in residents' training that occurs as a result of a natural disaster. The commenter stated that as a result of Hurricane Ike, which led to the declaration of an emergency area under section 1135(b) of the Act for parts of Louisiana and Texas, its facility quickly entered into an emergency Medicare GME affiliation agreement without first determining whether it needed a temporary cap increase. The commenter stated that facilities that acted as quickly as its hospital should not be penalized for taking such prompt action. The commenter believed that emergency Medicare GME affiliation agreements should not be considered in determining a hospital's otherwise applicable resident limit because "[f]rom a statutory perspective, the provision defining the 'otherwise applicable resident limit' only cross-references the routine Medicare GME affiliation agreement provisions in section 1886(h)(4)(H) of the Act. It does not cross-reference the emergency Medicare GME affiliation agreement legislative authority in section 1135(b) of the Act." The commenter indicated that if CMS decides not to account for emergency Medicare GME affiliation agreements in determining a hospital's otherwise applicable resident limit, CMS would not in turn reduce the FTE resident caps of hospitals located in emergency areas. Rather, the commenter suggested that CMS could exempt hospitals located in areas affected by an emergency from the cap redistribution on the basis that they were unable to train up to their FTE resident caps due to the natural catastrophes. The commenter stated that because the natural catastrophe led to the declaration of a public health emergency under section 1135(b) of the Act, "* * * the direct consequences of those events should also fall under the same waiver authority." The commenter stated "[i]mplicitly, the Affordable Care Act imposes a retrospective requirement on hospitals to have trained at a level at least equal to their FTE resident caps to avoid the penalty of the FTE cap reduction. With its section 1135(b) authority, CMS can waive this retrospective requirement effective with the date of the beginning of the emergency period."

Response: We commend the commenters for its hospital's participation in an emergency Medicare GME affiliation agreement to provide residents training in affected hospitals with continuity of training. We do not agree that an emergency Medicare GME affiliation agreement is fundamentally different from a regular Medicare GME affiliation agreement. Both types of affiliation agreements allow for a temporary adjustment to hospitals' FTE caps to permit residents to train at another facility. Furthermore, section 1886(h)(4)(H)(ii) of the Act, which gives the Secretary the authority to prescribe rules which allow members of the same affiliated group to elect to apply the members' caps on an aggregate basis, is the statutory foundation for the establishment of emergency Medicare GME affiliation agreements. Section 1135(b) of the Act only provides the Secretary with the authority to temporarily waive or modify the

requirements of a regular Medicare GME affiliation agreement; it did not provide the Secretary with the authority to create emergency Medicare GME affiliation agreements. We further note that the "emergency period" declared pursuant to section 1135(b) of the Act with respect to Hurricane Ike expired before the emergency Medicare GME affiliation agreements provision ended.

In response to the commenters request that CMS exempt hospitals that were unable to train up to their caps because of a natural disaster, section 1886(h)(8)(A) of the Act does not provide for specific exemption for hospitals located in an emergency area during an emergency period. We believe that section 1886(h)(8)(A) of the Act allows a hospital to account for its participation in a regular Medicare GME affiliated group and to account for its participation in an emergency Medicare GME affiliated group in determining a hospital's "otherwise applicable resident limit."

Therefore, we are finalizing our policy as proposed that based on the statutory language at section 1886(h)(8)(H)(iii) of the Act, in determining a hospital's otherwise applicable resident limit, we will generally consider a hospital's 1996 cap during its reference year, as adjusted for the following criteria: new programs as defined at § 413.79(e); participation in a Medicare GME affiliation agreement as defined at §§ 413.75(b) and 413.79(f); participation in an emergency Medicare GME affiliation agreement as defined at § 413.79(f); participation in a hospital merger; and whether an urban hospital has a separately accredited rural training track program as defined at § 413.79(k).

4. Exemption from FTE Resident Cap Reduction for Certain Rural Hospitals

Section 1886(h)(8)(A)(ii)(I) of the Act, as added by section 5503 of the Affordable Care Act, specifically exempts rural hospitals (as defined in section 1886(d)(2)(D)(ii) of the Act) with fewer than 250 acute care inpatient beds from reductions to their FTE resident caps under section 1886(h)(8)(A). Section 1886(d)(2)(D)(ii) of the Act defines a rural area as any area outside a Metropolitan Statistical Area (MSA). Under the existing regulations at § 412.62(f)(ii), an "urban area" means: (1) An MSA or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or (2) the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Under existing § 412.62(f)(iii), a "rural area" means any area outside an urban area. We note that we no longer use the term MSA, and instead use the term Core-Based Statistical Area (CBSA) for locality and wage index purposes.

A hospital's bed size is based on its number of available beds, as determined for IME payment purposes under § 412.105(b) of the regulations. For purposes of determining whether a rural hospital has fewer than 250 beds, we proposed to use data from the rural hospital's most recent cost reporting period ending on or before March 23, 2010. (This information may be found on Worksheet S–3, Part I of the Medicare cost report, CMS–2552–96: the sum of lines 1 and 6 through 10 in column 2, minus line 26 in column 6, divided by the number of days in the cost reporting period.) In the August 3, 2010 proposed rule (75 FR 46391 and 46392), we proposed that if a rural hospital has fewer than 250 beds in its most recent cost reporting period ending on or before March 23, 2010, the hospital would not be subject to a possible reduction to its FTE resident cap(s) under section 1886(h)(8)(A) of the Act. However, if a rural hospital has at least 250 beds in its most recent cost reporting period ending on or before March 23, 2010, we proposed that the rural hospital would be subject to a reduction to its FTE resident cap(s).

Comment: Several commenters supported the exclusion of rural hospitals with fewer than 250 beds from a cap reduction under section 1886(h)(8)(A) of the Act. The commenters stated it is important that these hospitals be exempt from a cap reduction and that excluding hospitals with fewer than 250 beds will ensure that section 5503 of the Affordable Care Act will not cause unnecessary harm to these rural hospitals. The commenter added that due to the rural workforce shortage, these rural hospitals have a need to retain their current residency slots which they already struggle to maintain.

One commenter requested clarification on the treatment of rural hospitals that have a temporary decrease in their available bed count due to, for example, a unit being closed for renovation. The commenter asked whether a hospital that only experiences a temporary decrease in its bed count would be exempt from a cap reduction because the bed count would probably increase once the renovation, for example, was completed. The commenter stated that the cost reports at issue, from the most recent cost reporting ending on or before March 23, 2010, will neither be audited nor reviewed by the Medicare contractor by the date cap reductions are made. The commenter asked for clarification on how the policy for exempting rural hospitals with fewer than 250 beds would be applied if the temporary reduction is later proven to be invalid. The commenter recommended "* * * that CMS require a review process to validate the bed size of rural hospitals that claim exemption from the FTE cap reduction due to their bed count."

Response: We appreciate the commenters' support of our proposed policy to exclude rural hospitals with fewer than 250 beds from cap reductions under section 1886(h)(8)(A) of the Act. In response to the commenter who requested clarification on whether rural hospitals that only had a temporary bed reduction, such that they meet the requirement of having fewer than 250 beds for a limited period of time, a hospital will be exempt from a cap reduction, regardless of whether or not the bed reduction is temporary, if the data on its cost report at issue indicates the hospital had fewer than 250 beds. We note that the determination regarding the availability of beds in a unit that is closed for renovation would be made in accordance with the existing regulations at § 412.105(b)(1), which states, "[b]eds in a unit or ward that is not occupied to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system at any time during the 3 preceding months (the beds in the unit or ward are to be excluded from the determination of available bed days during the current month)." We also are clarifying in this final rule that the Medicare contractor will determine whether a rural hospital has fewer than 250 beds by using the number of available beds on the rural hospital's most recently submitted cost report for its cost reporting period ending on or before March 23, 2010, for which a cost report has been settled or has been submitted to the Medicare contractor by March 23, 2010. That is, we are clarifying that the cost report used to determine whether the rural hospital is exempt from a cap reduction must have been settled or have been submitted to the Medicare contractor by March 23, 2010. In this final rule, we are revising § 413.79(m)(1) to reflect this clarification.

In response to the commenter's request that CMS require a review process to validate a rural hospital's bed count, the Medicare contractors will review rural hospitals' bed size in accordance with normal audit procedures.

5. Application of Section 5503 to Hospitals That Participate in Demonstration Projects or Voluntary Residency Reduction Programs and Certain Other Hospitals

In addition to certain rural hospitals as noted above, section 1886(h)(8)(A)(ii) of the Act also exempts certain other hospitals from a residency cap reduction. Section 1886(h)(8)(A)(ii)(II) of the Act, as amended by section 5503 of the Affordable Care Act, specifically exempts "a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90–248, if the hospital demonstrates to the Secretary that it has a specific plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph." This language is referring to the National Voluntary Residency Reduction Plan (VRRP), the New York Medicare GME Demonstration (New York Demonstration), and the Utah Medicare GME Demonstration (Utah Demonstration).

In July 1997, 42 New York teaching hospitals participated in the New York Demonstration. An additional seven hospitals joined the New York Demonstration in July 1998. The purpose of the New York Demonstration was to test reimbursement changes associated with residency training to determine whether hospitals could use time-limited transition funding to replace and reengineer the services provided by a portion of their residency trainees. In exchange for reducing its count of residents by 20 to 25 percent over a 5-year period, while maintaining or increasing its primary care-to-specialty ratio of residents, a participating hospital (or consortium of hospitals) participating in the New York Demonstration would receive "hold harmless payments" for 6 years.

Since 2003, nine Utah teaching hospitals have participated in the Utah Demonstration to allocate Medicare GME funding to Utah hospitals based on health professions workforce planning. Under the Utah Demonstration, Medicare contractors redirect Medicare direct GME funds from each of the teaching hospitals in Utah and pay those amounts to the Utah Medical Education Council, an agency of the State government.

Under the VRRP approved under section 1886(h)(6)(B) of the Act, hospitals could use time-limited transition funding to replace the services provided by a portion of their residents. In exchange for reducing its count of residents by 20 to 25 percent over a 5-year period, while maintaining or increasing its primary care-to-specialty ratio of residents, a VRRP participating hospital would receive "hold harmless payments" for 5 years.

Based on the language of section 1886(h)(8)(A)(ii)(II) of the Act, in the August 3, 2010 proposed rule (75 FR 46392), we proposed that hospitals that participated in the New York Demonstration, the Utah Demonstration, or a VRRP could be exempt from a cap reduction under section 1886(h)(8)(A) of the Act. We proposed to not differentiate between those hospitals that withdrew from either demonstration prior to its completion and those hospitals that completed either demonstration. That is, we proposed that any hospital that, at some point, participated in the New York Demonstration, the Utah Demonstration, or the VRRP could be exempt from a cap reduction. Specifically, consistent with the statutory language at section 1886(h)(8) of the Act, even though only seven hospitals actually completed the New York Demonstration, any hospital that participated in the New York Demonstration could be exempt from a cap reduction. As required under section 1886(h)(8)(A)(ii)(II) of the Act, to be exempt from the cap reduction, a hospital that had a VRRP approved under section 1886(h)(6)(B) of the Act or hospitals that participated in a demonstration project approved under section 402 of Public Law 90–248 must demonstrate to the Secretary that it has a plan in place for filling its unused slots within 2 years after the date of enactment of Public Law 111–148 (that is, by March 23, 2012). We proposed that those hospitals must submit their plans specifying how they would fill their unused slots to CMS by December 1, 2010, in order to be exempt from a cap reduction.

In addition to the hospitals described under 1886(h)(8)(A)(ii)(II) of the Act, section 1886(h)(8)(A)(ii)(III) of the Act exempts a hospital described under section 1886(h)(4)(H)(v) of the Act from a cap reduction. Therefore, in the August 3, 2010 proposed rule (75 FR 46392), we proposed that such a hospital described under section 1886(h)(4)(H)(v) of the Act be exempt from a cap reduction.

Finally, section 1886(h)(8)(H)(i) of the Act provides that the hospital's reference resident level is the resident level for the one cost reporting period out of the three most recent cost reporting periods ending before March 23, 2010, with the highest resident level. Under section 1886(h)(8)(A)(i) of the Act, that reference resident level is used to make the determination of whether a hospital's FTE resident cap(s) should be reduced. Therefore, in the August 3, 2010 proposed rule, we proposed that if a hospital trains at or above its otherwise applicable resident limit in all of its three most recent cost reporting periods ending before March 23, 2010, the hospital would be exempt from a cap reduction. A separate determination would be made regarding any reduction to the hospital's direct GME cap and its IME cap.

Comment: Several commenters supported our proposed policy to exclude hospitals that participated in the Utah Demonstration and the New York Demonstration if the hospitals submit their plans to CMS by December 1, 2010, specifying how they would fill their unused slots by March 23, 2012.

One commenter asserted that it is important for CMS to understand the structure, timeline, and post-demonstration requirements associated with the New York Demonstration. The commenter stated the terms and conditions for the seven hospitals that completed the New York Demonstration required that, if a hospital exceeded its post-demonstration cap, which was in effect until July 1, 2009, and reduced a participating hospital's cap 20 to 25 percent below its otherwise applicable Medicare resident cap, the hospital would be accountable for the Medicare GME reimbursement associated with its additional FTE residents. The commenter stated the hospitals that completed the New York Demonstration had to adhere to a separate lower Medicare resident cap through July 1, 2009, a requirement not applicable to other hospitals in the country. The commenter also noted that certain hospitals that did not complete the entire New York demonstration had already made substantial reductions to their FTE resident counts of 20 or 25 percent before formally ending their participation in the demonstration. The commenter stated, for this reason, it agrees with CMS' proposal to apply the Affordable Care Act exemption for hospitals that participated in the demonstration authority to hospitals that participated at any time in the New York Demonstration.

The commenter stated CMS' proposal to require that hospitals that participated in the New York Demonstration submit a plan to CMS by December 1, 2010, for how they plan to fill their slots by March 23, 2012, is unrealistic, given that the final rule will not be available until November 1, 2010, and "* * * given the magnitude of the reductions required by CMS and the fact that CMS mandated an incentive to

maintain those large reductions through July 1, 2009." The commenter requested that CMS finalize a policy that hospitals that participated in the New York Demonstration be required to submit a plan to CMS by March 1, 2011, for how they plan to fill their unused slots by March 23, 2012. The commenter suggested that if CMS needs an estimate of the number of slots the demonstration hospitals plan to fill by March 23, 2012, CMS could require a two-step process by which hospitals would provide to CMS by December 1, 2010, an estimate of the number of FTE resident slots they plan to fill and provide to CMS by March 1, 2011, a detailed plan for how they anticipate to fill those slots.

The commenter noted that some hospitals that participated in the New York Demonstration accepted displaced residents from hospitals that closed after March 23, 2008. The commenter recommended that CMS allow, but not require, hospitals that participated in the New York Demonstration to "* * * include as part of its submitted plan for filling unused slots by March 23, 2012 its intention to apply for additional slots to continue training residents in the same program as displaced residents from a closed hospital, if the hospital desires to do so." The commenter believed that CMS' interpretation that demonstration hospitals must have residents training in the hospitals' unused slots as of March 23, 2012, is not practical because it cannot be reconciled with the "core characteristic of residency training," that residents begin their applicable program years July 1 of each calendar year. The commenter added that CMS' interpretation means that a hospital would have to have residents training in the unused slots by July 1, 2011, to ensure these residents are actually training as of March 23, 2012, which would only allow these hospitals approximately 15 months to fill their unused slots rather than 2 years. The commenter stated "[t]he more sensible approach to interpreting this requirement would be for CMS to permit the demonstration hospitals to specify a plan whereby the hospitals will fill the unused slots in a progressive and logical manner that recognizes the staggered nature of residency training." Therefore, the commenter recommended that the unused FTE resident cap slots of hospitals that participated in the New York Demonstration be considered to be filled by March 23, 2012, if any one of the following three scenarios occurs: (1) A resident is actually training at the hospital by March 23, 2012; (2) a resident is enrolled in a hospital's unused cap slot by March 23, 2012, and will begin training no later than July 1, 2012; or (3) "there is a demonstrated likelihood of slots in a new program being filled in a progressive sequence as evidenced by the matching to or enrollment in the program of the first cohort of residents by that date and that first cohort will begin training in the slots no later than July 1, 2012."

Response: We appreciate the commenters' support of our proposed policy that if a hospital at any time participated in the New York Demonstration or the Utah Demonstration, it would be exempt from a cap reduction if it submits a plan to CMS by December 1, 2010, for how it plans to fill its unused slots by March 23, 2012. We understand the commenter's concern that the proposed requirement to submit a plan to CMS by December 1, 2010, for how the hospital plans to fill its slots by March 23, 2012, may not provide hospitals that participated in the New York demonstration sufficient time to draft their plans. Therefore, we are amending our proposed policy in this final rule to require hospitals that participated in the New York Demonstration, the Utah Demonstration, or a VRRP to submit their plans to CMS by January 21, 2011, for how they plan to fill their unused slots by March 23, 2012. We are revising the proposed regulatory text at § 413.79(m)(2) to reflect this date change.

In response to the commenter's question of whether applying for FTE cap slots from a closed hospital under section 5506 of the Affordable Care Act could be considered part of a hospital's plan for filling unused slots by March 23, 2012, we do not agree that showing that a hospital is applying for cap slots under section 5506 demonstrates that the hospital will be filling its unused cap slots by March 23, 2012. On the contrary, applying for additional cap slots under section 5506 of the Affordable Care Act would give a demonstration hospital an additional cap, which could further increase its number of unused slots.

In response to the commenter's concerns regarding the likelihood of having additional residents training as of March 23, 2012, we are stating in this final rule that if a hospital described under section 1886(h)(8)(A)(ii)(II) of the Act can show that a resident(s) has matched into a program by March 23, 2012, or has signed a formal letter of commitment with the program by March 23, 2012, and that a resident(s) will begin training no later than July 1, 2012, that hospital has met the requirement of demonstrating that it has a plan for filling an unused cap slot(s) by March 23, 2012. We note that, for purposes of submitting a plan indicating that the hospital will fill its unused slots by March 23, 2012, the type of documentation required to demonstrate that the hospital is filling unused slots must be the type of documentation listed under the demonstrated likelihood criteria for purposes of implementing cap increases under section 5503 of the Affordable Care Act. For example, the hospital could submit to CMS the documentation it submitted to the ACGME requesting approval for a new program or a permanent expansion to the number of residents in its existing program.

In summary, we are finalizing our proposed policies regarding the treatment of hospitals that participated in the New York Demonstration, the Utah Demonstration, and a VRRP, and a hospital described under section 1886(h)(4)(H)(v) of the Act, except that we are allowing hospitals to submit their plans to CMS by January 21, 2011, for how they plan to fill their unused slots by March 23, 2012. We also are allowing hospitals that participated in the New York Demonstration, the Utah Demonstration, or a VRRP to demonstrate that they are filling unused slots by March 23, 2012, by showing that a resident(s) has matched into a program by March 23, 2012, or has signed a formal letter of commitment with the program by March 23, 2012, and will begin training at the hospital at the latest by July 1, 2012.

We also are clarifying in this final rule that a hospital that is training at or above its otherwise applicable resident limit in all three of its three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been either settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010, is exempt from a cap reduction under section 1886(h)(8)(A) of the Act. A separate determination would be made regarding any reduction to the hospital's direct GME cap and its IME cap.

6. Determining the Estimated Number of FTE Resident Slots Available for Redistribution

In accordance with section 1886(h)(8)(A) of the Act, as added by section 5503 of the Affordable Care Act, we will determine the number of resident positions available for redistribution by estimating the expected reductions to hospitals' FTE resident caps. We believe that section 1886(h)(8)(A) of the Act allows us to distinguish between the FTE counts that are used to determine the number of

FTE resident slots that are available for redistribution (that is, the "redistribution pool") and the actual number of FTE residents by which hospitals' FTE resident caps are ultimately reduced. In the August 3, 2010 proposed rule (75 FR 46392 and 46393), we proposed to estimate the reduction to a hospital's FTE cap under section 1886(h)(8)(A) of the Act for purposes of determining the number of FTEs that a hospital might contribute to the redistribution pool. We proposed to estimate the redistribution pool in accordance with section 1886(h)(8)(B)(i) of the Act, as added by section 5503(a)(4), which states: "The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (*as estimated by the Secretary*)" (emphasis added). Therefore, we proposed to estimate and redistribute the number of resident slots in the redistribution pool, and to ensure that the aggregate number of FTE residents by which we increase the FTE resident caps of qualifying hospitals under section 1886(h)(8)(B) of the Act is not more than CMS' estimate of the redistribution pool. In the proposed rule, we noted if we were subsequently to perform an audit, as described further in section XXI.D.7. of this preamble, in order to make a final determination regarding any reductions to a hospital's FTE resident cap, and find that the aggregate number of FTE resident reductions differed from the number CMS had initially estimated for the redistribution pool, the number of slots that can be redistributed from the redistribution pool to qualifying hospitals would not be affected.

To ensure that we would begin making payments for most hospitals based on the revised FTE resident caps by July 1, 2011, as required by the statute, in the August 3, 2010 proposed rule (75 FR 46393), we proposed to set a date by which we would have determined a hospital's reference resident level and compared it to the hospital's otherwise applicable resident limit(s) to estimate whether, and by how much, the hospital's FTE cap(s) would be reduced. We proposed this date to be May 1, 2011, and that date would apply for all hospitals for purposes of determining an estimate of whether and by how much their FTE resident caps should be reduced. In the event that the Medicare contractors have not completed an audit of a hospital's GME data (explained further under section XXI.D.7. of this preamble) by May 1, 2011, we proposed to estimate by May 1, 2011, the number of FTE residents by which a hospital's FTE resident cap is expected to be reduced based on the data in the as-submitted cost report. For example, a Medicare contractor may estimate by May 1, 2011, that Hospital A's FTE resident cap should be reduced by 10 FTEs. Thus, we would place 10 FTEs into the redistribution pool. It is possible that even after May 1, 2011, the contractor may continue to audit Hospital A's relevant cost reports to determine if, in fact, 10 FTEs is the appropriate number by which to reduce Hospital A's FTE resident cap, and could ultimately conclude that Hospital A's FTE resident cap should only be reduced by 8 FTEs. If the Medicare contractor does not make this revised determination based on the audit by May 1, 2011, while we would only reduce Hospital A's FTE resident cap by 8 FTEs effective July 1, 2011, the number of FTE residents in the redistribution pool attributable to Hospital A would remain at 10 FTEs (the estimated number as of May 1, 2011). Similarly, if the Medicare contractor ultimately concluded that Hospital A's FTE resident cap should be reduced by 12 FTEs, but this final determination is not made by May 1, 2011, Hospital A's FTE resident cap would be reduced by 12 FTEs effective July 1, 2011, but the number of FTE residents in the redistribution pool attributable to Hospital A would remain at 10 FTEs. Therefore, because we believe that section 1886(h)(8)(B)(i) of the Act allows us to distinguish between the FTE counts that are used to determine the size of the redistribution pool, and the actual aggregate number of FTE residents by which hospitals' FTE resident caps are ultimately reduced, we proposed to use estimated information to determine possible reductions to hospitals' FTE resident caps to estimate the number of FTE resident slots to be distributed under section 1886(h)(8)(B) of the Act. In addition, we noted that, as was done when we implemented section 422 of Public Law 108–173, Medicare contractors will provide hospitals with a time-limited opportunity to review cap reduction determinations for possible technical errors before they are finalized. As set forth at section 5503(a)(3), cap reduction determinations are not subject to administrative or judicial review.

Comment: One commenter believed that the proposal for CMS to distinguish between the estimated number of positions available for redistribution and the actual number of positions by which hospitals' FTE residency caps ultimately would be reduced is a reasonable proposal. However, the commenter was concerned that an underestimate of available positions could result in reducing the universe of GME positions. The commenter recommended that CMS consider reconciling the number of positions lost with the number awarded after cost reports are audited, applications evaluated, and the redistribution process complete. Further, the commenter stated that this additional step should not result in loss of positions once they are awarded.

One commenter asked how Medicare contractors are to estimate the number of slots available by May 1, 2011, because the cost reports at issue will not be audited in the timeframe in which the resident information is needed. The commenter stated that cost report settlements for disproportionate share hospitals (DSHs), many of which are also teaching hospitals, are delayed until CMS can supply revised Supplemental Security Income (SSI) ratios. The commenter stated that final settlements have not been issued for cost reporting periods beginning in FY 2006 and for subsequent cost reporting periods. The commenter asked whether CMS is proposing to use cost reports that have not been final settled to perform the FTE cap redistribution. The commenter also asked whether there would be "* * * special, abbreviated audits or settlements made specific to the FTE resident counts for those years in order to ensure that the data used to redistribute the FTE caps is reviewed by the Medicare contractor and settled appropriately." The commenter suggested that, in establishing any additional workload requirements for Medicare contractors for purposes of section 5503 of the Affordable Care Act, CMS consider other Medicare contractor workload requirements, including settlement of DSH appeals under CMS Ruling 1498 and wage index reviews, which have to be completed in the same timeframe.

One commenter noted that implementation of section 5505 of the Affordable Care Act may increase a hospital's reference resident levels for didactic time in the hospital's three most recent cost reporting periods submitted before March 23, 2010. The commenter asked whether hospitals' reference resident levels would be modified to account for any additional resident FTEs. The commenter asked whether if adjustments are to be made, they would be made for all affected hospitals or only for those hospitals that have a jurisdictionally valid appeal. The commenter stated that the section 5505 provisions will be available for all

providers when the FTE cap reductions are applied in subsequent cost reporting periods.

One commenter believed that reference resident levels used for purposes of reducing hospitals' caps under section 5503 of the Affordable Care Act should be based on years that will include additional FTEs based on additional FTE time spent at nonprovider sites that is due to the changes made by section 5504 of the Affordable Care Act. The commenter stated that its hospital is below its cap because it has not been allowed to include weeks spent by residents at nonprovider sites. The commenter stated that if its hospital's cap is reduced, this action would eliminate any benefit it may receive by being able to count additional rotations at nonprovider sites. The commenter also referred to the recordkeeping requirement included in section 5504 of the Affordable Care Act. The commenter stated "It does not seem logical to reduce caps while at the same time monitoring for increases in FTEs for time spent in nonprovider settings." The commenter stated that redistributing FTE cap slots should be delayed until adjustments have been made to hospitals' FTE counts for weeks spent at nonprovider settings.

Several commenters supported CMS' proposal to provide hospitals with a time-limited opportunity to review cap reductions for any possible technical errors before the reductions are finalized.

Response: In response to the commenter who recommended that CMS reconcile the number of FTE cap slots reduced with the number of FTE cap slots awarded, we note that we are not required to reconcile the cap reductions with the caps awarded under the provisions of section 5503 of the Affordable Care Act. Specifically, section 1886(h)(8)(B)(i) of the Act, in part, states "The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (*as estimated by the Secretary*)" (emphasis added). We believe the use of the phrase "as estimated by the Secretary" gives the Secretary the authority to estimate the FTE redistribution pool for purposes of finality. We and the Medicare contractors will endeavor to make cap reduction determinations based on the most accurate data available. However, because some of the audits to finally determine whether a hospital has excess slots will not be completed prior to July 1, 2011, and because the statutory effective date of the increases to hospitals' caps is July 1, 2011, we are not changing our proposed policy and, therefore, we are not reconciling the number of FTE cap slots reduced with the number of FTE cap slots awarded. Doing so would preclude implementation of section 5503 of the Affordable Care Act by its effective date, July 1, 2011.

In response to the commenter who requested clarification on how Medicare contractors can estimate the FTE redistribution pool as of May 1, 2011, as we note in a subsequent comment, we are moving the internal deadline for Medicare contractors to estimate the number of slots available for redistribution from May 1, 2011 to May 16, 2011. As we did when implementing section 422 of the MMA, we will be issuing separate instructions to the Medicare contractors regarding the process for determining if and by how much a hospital's FTE resident cap should be reduced. We understand that many cost reports used for determining if and by how much a hospital's FTE resident cap might be reduced will not be final settled, or may not even be audited under normal cost report settlement procedures. We note that section 1886(h)(8)(H) of the Act directs the Secretary to use the highest resident level (as the reference resident level) for any of a hospital's three most recent cost reporting periods ending before the date of enactment, which is March 23, 2010, "for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary." Thus, the Secretary has the flexibility to use either settled cost reports, if available, or not as yet settled cost reports, and subject those cost reports, or parts of those cost reports, to audit, as appropriate. In response to the commenter's concern about additional Medicare contractor workload requirements, we understand the competing audit and payment priorities the Medicare contractors face in the upcoming months, and we will make every effort to be accommodating to those concerns.

In relation to the issue of adding in FTE resident time for didactic time previously disallowed for purposes of IME in the hospital setting and for purposes of direct GME in the nonprovider setting as provided by section 5505, the hospital's cost report must either not have been settled or must have a jurisdictionally proper appeal pending by March 23, 2010, for IME to include didactic time in prior cost reporting periods for IME payment purposes. For purposes of direct GME in the nonprovider setting, the hospital's cost report must either not have been settled or must have a jurisdictionally proper appeal pending for direct GME to include didactic time in a prior cost reporting period starting on or after July 1, 2009 (but ending before March 23, 2010) for direct GME payment purposes. If an audit of a hospital's cost report is performed by May 16, 2011, and as a result of that audit, a hospital's cost report includes the additional didactic time, that adjustment will be reflected in the estimate of the FTE redistribution pool. Because in this final rule we are finalizing our proposed policy to give Medicare contractors until December 31, 2011, to continue their audit work with respect to reductions under section 5503 of the Affordable Care Act, adjustments to hospitals' cost reports for didactic time as a result of audit work through December 31, 2011, for purposes of calculating any cap reductions, will be retroactive to July 1, 2011. However, changes made between May 16, 2011 and December 31, 2011 will not be included in the estimated pool. We note that including this didactic time prior to determining whether a hospital should receive a cap reduction is contingent on Medicare contractor workload. That is, we must use the most recent cost report data we have available in order to make the determination of whether a hospital's cap should be reduced in such a manner that section 5503 can be implemented by July 1, 2011.

In response to the commenter who requested clarification on whether time FTE residents spent in nonprovider settings, which was disallowed, would be added into a hospital's FTE count, prior to determining whether the hospital should receive a cap reduction, we note that section 5504 of the Affordable Care Act is effective prospectively for cost reporting periods beginning on or after July 1, 2010. Because we are stating in this final rule that cost reports used to determine a hospital's reference resident level must be settled or submitted to the Medicare contractor by March 23, 2010, section 5504 will have no bearing on a hospital's reference cost reporting period because those amendments are only effective for cost reporting periods beginning on or after July 1, 2010.

7. Reference Cost Reports That Are Under Appeal

We understand that there may be instances where a hospital's otherwise applicable resident limit or a hospital's FTE resident count for a reference cost reporting period might be under appeal. When implementing section 422 of Public Law 108–173, we stated in the August 11, 2004 **Federal Register** (69 FR

49118) that we believe that it is in the best interest of the Medicare program, CMS, the contractors, and the hospitals to adopt an approach that allows for finality as early as possible during the process of implementing this provision. We stated that we believed Congress gave some consideration to the challenges we would encounter in implementing a provision as complex as section 422 in such a short timeframe by providing the Secretary with the discretion to distinguish between the FTE counts that are used to estimate the number of FTE resident slots that are available for redistribution (that is, the "redistribution pool"), and the actual number of FTE residents by which hospitals' FTE resident caps are ultimately reduced.

Furthermore, as we stated in the August 11, 2004 **Federal Register** (69 FR 49118), the fact that the Congress took the unusual step of including the language at section 1886(h)(7)(D) of the Act which provides that, "There shall be no administrative or judicial review * * * with respect to determinations made under this paragraph," supports the position advocating for finality. If we had delayed determinations concerning hospital-specific FTE cap determinations until all affected cost reports are settled, audited, and appealed through the various channels normally available to providers, the language, and in particular the specified timeframe, under section 1886(h)(7)(D) of the Act would have been rendered meaningless. Therefore, despite the complexity of section 422 and the potential for profound and long-term GME payment ramifications, we believed that the Congress did not expect the implementation of section 422 provision to linger indefinitely. Rather, by limiting appeal rights and requiring an effective date of July 1, 2005 for reductions in FTE resident caps (which required implementation in a relatively short timeframe), the Congress expected section 1886(h)(7) of the Act, as added by section 422 of Public Law 108–173, to be implemented with expediency and finality.

Similarly, in implementing section 5503 of the Affordable Care Act, we note that determinations under section 1886(h)(8)(A)(i) of the Act are required to be made by and effective July 1, 2011, and, for the same reasons cited when we implemented section 422, we believe these determinations should be final on, or as quickly as possible after, that date. We note that section 5503(a)(3) of the Affordable Care Act modified section 1886(h)(7)(E) of the Act by inserting "or paragraph (8)" to specify that there shall be no administrative or judicial review with respect to determinations made under section 5503 as well. Therefore, as was our final policy when implementing section 422, in the August 3, 2010 proposed rule (75 FR 46393), we proposed to not wait for all appeals of reference period cost reports to be resolved before making a final determination as to whether and by how much a hospital's FTE resident cap will be reduced. However, we indicated that we did perceive the need in certain instances to continue audit work for a limited time period past July 1, 2011, to promote the accuracy of FTE resident cap reduction determinations. As under section 422, we proposed to adopt a policy that would require the Medicare contractors to use the latest available cost report or audit data at the time they make their hospital-specific determinations. We proposed that if, as of the time the Medicare contractor makes the determination as to whether and by how much a hospital's FTE resident cap should be reduced, there is a pending appeal of the hospital's otherwise applicable resident limit for the reference cost reporting period (that is, a final decision has not been rendered), the Medicare contractor would not wait until a decision is rendered, but would use the FTE resident cap from the initially settled (as indicated in the Notice of Program Reimbursement (NPR)) reference period cost report. However, we proposed that if the appeal regarding the otherwise applicable resident limit has been resolved as of the time that the Medicare contractor makes the determination as to whether and by how much a hospital's FTE resident cap should be reduced, the Medicare contractor would use the FTE resident level as established through the appeal. We proposed that if a reference period cost report has been submitted but not settled at the time the Medicare contractor is making the determination as to whether and by how much a hospital's FTE resident cap should be reduced, the reference resident level is subject to audit by the Medicare contractor. The final determination regarding any possible reduction to the hospital's FTE resident cap is not subject to appeal. We indicated that although we would make every effort to provide contractors with the resources they need to complete the audits in time to notify each hospital by July 1, 2011, of their FTE cap determinations under section 1886(h)(8)(A) of the Act, there may be instances where the audits of the reference resident levels may not be completed by July 1, 2011. We stated that we anticipate that, within the scope of their normal audit work, the Medicare contractors will complete as many of these audits as possible, and some of the audits may not be completed until December 31, 2011. In the August 3, 2010 proposed rule (75 FR 46394), we proposed that, in accordance with section 1886(h)(8)(A) of the Act, all cap determinations made after July 1, 2011 and through December 31, 2011, would be effective retroactively to July 1, 2011.

Comment: One commenter disagreed with the proposal to not correct a hospital's FTE count due to the resolution of a hospital's appeal, unless the appeal is resolved prior to July 1, 2011. The commenter stated that "* * * Congress' determination to preclude judicial and administrative review does not give license to CMS to lock in erroneous FTE counts." The commenter stated that this same policy negatively impacted its hospitals under section 422 and will likely have a significant future impact. The commenter indicated that, under section 422, its "reference period" for calculating the section 422 cap was FY 1997. The commenter indicated that it had appealed its FY 1997 IME count as inappropriately excluding certain residents training in its psychiatric residency program. The commenter stated that, in June 2006, it entered into an administrative resolution with its Medicare contractor to include these psychiatric FTEs in its IME count. However, the commenter added, the cap was not adjusted and the IME cap remains permanently understated. The commenter stated that, as a result of the IME cap being understated, the hospital must either operate its residency program at the inappropriately reduced cap, or operate its residency program above its cap without appropriate IME reimbursement. The commenter stated that it may continue to appeal its FTE resident counts for more recent fiscal years and those years may include the year that is the new reference cost reporting period for purposes of section 5503 of the Affordable Care Act. The commenter stated that not correcting FTE resident caps for purposes of section 5503 would have the same result as under section 422. The commenter believed an erroneous cap could compound problems because the FTE resident caps could be even further reduced leading to losses in IME payments and could restrict a hospital's ability to operate its program at or near the appropriate cap levels. The commenter suggested a preferred approach that CMS provide for finality as late in the process as possible and that, at a minimum, CMS instruct its

Medicare contractors to resolve relevant cost report appeals and/or reopening requests as quickly as possible before the 2011 deadline.

Another commenter stated that CMS in the proposed rule did not define "audit." The commenter believed that the estimate of unused FTE cap slots should be derived from cost reports that are filed, amended filed, or settled. The commenter stated "[i]t is unclear why CMS chose May 1, 2011, when all of the cost reports that will be used to estimate the unused FTE caps have already been submitted or settled." The commenter suggested that the "measurement date" be changed to December 31, 2010, which is prior to the "match" date so that hospitals will be able to adjust the number of residents it is training for the July 1, 2011–June 30, 2012 academic year and so that Medicare contractors will have sufficient time to resolve any differences in the calculation of unused caps. The commenter stated that, although finality is important, the proposal to retroactively adjust a hospital's FTE cap as a result of audit work completed by December 31, 2011, is not consistent with CMS' desire for finality. The commenter recommended that the data used to estimate the FTE cap pools be final with no additional adjustments. The commenter stated "[t]his will ensure that the aggregate 1996 FTE cap pool is not affected by implementation of section 5503."

Another commenter stated that, in prior final rules, CMS has permitted determinations to be subject to audits, reopenings, and appeals within the appropriate guidelines. The commenter recommended that this final rule be treated in the same manner.

Response: We believe that we need to consider the need for accuracy and for finality in determining any reductions to a hospital's cap under section 5503 of the Affordable Care Act. Therefore, as we stated in the proposed rule, we will make every effort to provide Medicare contractors with the resources they need to complete as many audits as possible in time to notify each hospital by July 1, 2011, of their FTE cap determinations. However, in the instances where audits of the reference resident levels may not be completed by July 1, 2011, as we stated in the proposed rule, we anticipate that within the scope of their normal audit work, the Medicare contractors will complete as many of these audits as possible, and some of the audits may not be completed until December 31, 2011. We believe it would be disruptive to the Medicare contractors and to the implementation of section 5503 of the Affordable Care Act if we extended the deadline to continue audit work past December 31, 2011.

In regards to the commenter who suggested that we move the "measurement" date from May 1, 2011 to December 31, 2010, as noted elsewhere in this preamble, in this final rule, we are changing the date by which Medicare contractors need to estimate a pool of reduced cap slots for purposes of redistributing the slots under section 5503 from May 1, 2011, to May 16, 2011. We are not able to change this date to December 31, 2010, because this final rule is not effective until January 1, 2011. Furthermore, only giving Medicare contractors until December 31, 2010, will not give them sufficient time to review submitted cost reports.

In response to the commenter who stated that CMS did not define "audit" work, as noted above, we stated in the proposed rule that determinations related to hospitals' cap reductions under section 1886(h)(8)(A) of the Act would be completed in the course of the CMS' contractors normal audit work (that is, the normal process the Medicare contractors utilize to review hospital cost reports for accuracy.)

In response to the commenter who believed that determinations made under section 5503 of the Affordable Care Act should be subject to audits, reopening, and appeals within the appropriate guidelines, the statutory language for implementing section 5503 specifically precludes us from permitting administrative and judicial review of the determinations made under this provision.

After consideration of the comments we received on this section, we are finalizing our policies as proposed. That is, we are finalizing our proposed policy to not wait for appeals of reference period cost reports to be resolved before making a final determination as to whether and by how much a hospital's FTE resident cap will be reduced. In addition, we are finalizing our proposed policy that all cap determinations made after July 1, 2011, and through December 31, 2011, would be effective retroactively to July 1, 2011.

8. Determining the Reduction to a Hospital's FTE Resident Cap

a. Reference Resident Level—General

In order to determine if a hospital's reference resident level is less than the hospital's otherwise applicable FTE resident cap, section 1886(h)(8)(H) of the Act, as added by section 5503 of the Affordable Care Act, directs the Secretary to use one of three reference cost reporting periods. Section 1886(h)(8)(H) of the Act directs the Secretary to use any of a hospital's three most recent cost reporting periods ending before the date of enactment, which is March 23, 2010, with the highest resident level "for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary," as the reference period. Generally, if the hospital's resident level for either direct GME or IME is less than the hospital's otherwise applicable resident limit for direct GME or IME, respectively, in the reference period, the hospital's FTE resident cap for direct GME and/or IME will be reduced by 65 percent of the difference between the resident level and the otherwise applicable resident limit. We note that, for purposes of determining a reduction to a hospital's direct GME cap, the unweighted direct GME cap will be compared to the unweighted direct GME FTE resident count. The following explanation is an example of how a hospital's cap(s) would be reduced under section 1886(h)(8)(A) of the Act. For purposes of this example, Hospital A's three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been submitted to the Medicare contractor by March 23, 2010, are as follows: July 1, 2006–June 30, 2007; July 1, 2007–June 30, 2008; and July 1, 2008–June 30, 2009. Hospital A's FTE resident count and FTE resident caps (as adjusted for those items discussed in section XXI.D.3. of this preamble) are as noted in the table.

Cost reporting period	IME unweighted FTE count	Direct GME unweighted FTE count	IME FTE cap	Direct GME cap
July 1, 2006—June 30, 2007	17	20	18	20
July 1, 2007—June 30, 2008	16	21	20	20
July 1, 2008—June 30, 2009	14	20	20	20

As noted earlier in this preamble, a separate determination regarding whether and by how much to reduce a hospital's cap will be made for its direct GME cap and for its IME cap. In order to determine whether Hospital A would be subject to a cap reduction, we must first determine whether Hospital A was training at or above its cap in all three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been settled or has been submitted to the Medicare contractor by March 23, 2010. For purposes of a reduction to Hospital A's IME cap, we note from the chart above that in all three cost reporting periods, Hospital A is training below its otherwise applicable resident limit for IME. Therefore, we know that Hospital A would be subject to an IME cap reduction. In order to determine which cost reporting period should be used as the reference period to determine the FTE cap reduction for IME, we would use the cost reporting period with the highest FTE resident count for IME, which would be July 1, 2006–June 30, 2007. Therefore, we calculate the difference between the otherwise applicable resident limit for IME for the reference period (July 1, 2006–June 30, 2007) and the reference resident level for IME, and determine the IME cap reduction based on 65 percent of the difference. For purposes of Hospital A's IME cap reduction, we would determine the difference between 18 (the otherwise applicable resident limit) and 17 (the reference resident level) and multiply that difference by 65 percent [(18–17) x .65] = 0.65. Therefore, the IME FTE cap for Hospital A would be reduced by 0.65 of an FTE. For purposes of a reduction to Hospital A's direct GME cap, we note from the chart above that Hospital A was training at or above its otherwise applicable resident limits for direct GME in all three cost reporting periods. Because a hospital that is training at or above its cap in all three cost reporting periods is exempt from a cap reduction, we would conclude that Hospital A's direct GME cap would not be reduced for direct GME payment purposes. We note that, in the August 3, 2010 proposed rule (75 FR 46394), we proposed that if a hospital has the same resident level for two or more cost reporting periods and that resident level is the "highest" resident level, we would use the cost reporting period of those "highest" cost reporting periods in which there is the least amount of difference between the resident level and the otherwise applicable resident limit to determine a cap reduction.

Comment: Many commenters disagreed with CMS' proposal that if a hospital's reference resident level is below its otherwise applicable resident limit during the hospital's reference cost reporting period, the hospital would receive a cap reduction even though that hospital might be training at or above its cap in one or both of the other two cost reporting periods. The commenters stated that a hospital should only receive a cap reduction if it is training below its FTE resident cap in *all* three of its three most recent cost reporting periods ending before March 23, 2010. One commenter disagreed with the suggestion by another commenter to exempt from a cap reduction any hospital that is training over its cap in any one cost reporting period out of the three most cost recent cost reporting periods ending before March 23, 2010. The commenter recommended that CMS finalize its proposal to only exempt hospitals that are training over their cap in all three cost reporting years.

Commenters stated it is possible that a hospital that is training at or above its FTE resident caps in 1 or 2 years of the hospital's three most recent cost reporting periods ending before March 23, 2010, which the commenters referred to as the 3-year look-back period, may lose cap slots because if the hospital is participating in a Medicare GME affiliated group, its cap may change from year to year and the year with the highest FTE resident count may not be the year with the least amount of difference between the FTE resident cap and the FTE resident count. The commenters believed that Congress' intent was only to redistribute "unused" cap slots and therefore, if a hospital was training at its cap or exceeded its cap in any cost reporting period included in the 3-year look-back period, it is clearly using its cap slots and should not receive a cap reduction. The commenters noted that they understood that CMS may have been obligated to interpret the term "reference resident level" as referring to the cost reporting period with the highest FTE resident count because of the statute's use of the phrase "the highest resident level." However, the commenters believed that Congress' instruction was that the "reference resident level" is to be "determined by the Secretary" and, therefore, CMS has the authority to finalize a policy that exempts a hospital that is training at or above its cap at some point during the 3-year look-back period, from a cap reduction. The commenters requested that CMS amend the regulations at proposed § 413.79(m)(4) to exempt, from a cap reduction, a hospital that is training at or above its otherwise applicable resident limit "for any of the three most recent cost reporting periods ending prior to March 23, 2010." The commenters stated that this suggested regulatory change would prevent "perverse consequences" for hospitals that participate in Medicare GME affiliated groups, which cause their adjusted FTE resident caps to change from year to year. The commenters gave the example of a hospital that could be training under its cap in 2007, but is training over its cap in 2008 and 2009; however, 2007 is the year with the highest resident count and, therefore, even though the hospital is training above its cap in 2008 and 2009, it would receive a cap reduction based on 65 percent of the unused cap slots based on data from the 2007 cost report.

One commenter stated the definition of "reference resident level" in the Affordable Care Act indicates that the "reference resident level" is comprised of only one year, the one cost reporting period out of the three most recent cost reporting periods with the highest resident level. The commenter believed that because a hospital's cap will not be reduced if its "otherwise applicable resident limit" exceeds its reference resident level," as long as the FTE resident count in any one of the three cost reporting periods exceeds the "otherwise applicable resident limit," it does not matter if the hospital is training below its cap in the two remaining cost reporting periods; the hospital will not receive a cap reduction. The commenter stated that this logic is not included in the preamble discussion, but, rather, when referring to a cost reporting period in which a hospital is training over its cap, the word "any" is replaced by the word "all." The commenter stated "[w]hile the actual proposed definition included in the new regulation 42 CFR 413.79(c)(1)(ii)(A) includes the correct wording of 'any', the subsequent discussion regarding the implementation of this regulation is not consistent with the plain reading of the definition. The inclusion of the word 'all' in the discussion suggests that the 'reference resident level' does not refer to a single year but to all of the three most recent years. This implies that if one of the resident levels falls below the 'otherwise applicable resident limit,' then a hospital will have its cap reduced, even if the remaining two years of its three year reference period are above the 'otherwise applicable reference level.'" The commenter stated that, historically, the Provider

Reimbursement Manual has been used by Medicare to provide guidance to auditors. However, recently, the commenter added, it appears that preamble discussion has been substituted as guidance for auditors. The commenter stated that including the word "all" in the preamble discussion is confusing and may put auditors in a position where they cannot correctly implement regulation and the law. The commenter stated that if a hospital's reference resident level is greater than its otherwise applicable resident limit, but its FTE count is less than its otherwise applicable resident limit in one or both of the two remaining cost reporting periods, the auditors may perceive that based on the preamble discussion that FTE resident counts in all three of the cost reporting periods must be above the otherwise applicable resident limit in order for the hospital to be exempt from a cap reduction and inappropriately reduce the hospital's FTE resident count. The commenter noted that because hospitals do not have appeal mechanisms available to them related to the cap reductions and because there is contradictory guidance included in the preamble of the proposed rule, hospitals may have their caps inappropriately reduced. The commenter suggested that this issue be clarified in the final rule so that audits that implement the cap reductions can be performed correctly and consistently.

Another commenter stated "CMS proposes that if a hospital trains at or above its otherwise applicable resident level in all of its three most recent cost reporting periods ending before March 23, 2010, the hospital would be exempt from a cap reduction." The commenter stated that this provision is unclear and asked whether CMS is referring to hospitals that are training FTE residents at levels above their FTE caps.

Response: We stated in the proposed rule that section 1886(h)(8)(H)(i) of the Act directs the Secretary to use as the reference cost report, the one cost report out of the hospital's three most recent cost reporting periods ending before March 23, 2010, with the highest unweighted resident count "for which a cost report has been settled (or, if not, submitted (subject to audit), as determined by the Secretary." Generally, if the hospital's reference resident level for either direct GME or IME is less than the hospital's otherwise applicable resident limit for direct GME or IME, respectively, in the reference period, the hospital's FTE resident cap for direct GME or IME will be reduced by 65 percent of the difference between the reference resident level and the otherwise applicable resident limit. We understand the commenters' concerns that if a hospital is participating in a Medicare GME affiliated group, even though that hospital may be training below its cap, the Medicare GME affiliated group as whole is training above its aggregated cap and, therefore, the individual hospital should not have its cap reduced for training residents below its otherwise applicable limit. However, as discussed further below, section 1886(h)(8)(A) of the Act does not provide for treatment of GME affiliated groups as whole. In contrast, section 422 of the MMA included specific language at section 1886(h)(7)(A)(iii) of the Act that specifically directed the Secretary to apply the provisions for determining programs subject to reductions under section 422 to hospitals that are members of the same affiliated group. Section 5503 does not include similar language. In addition, we note that the definition of "reference resident level" at section 1886(h)(8)(H)(i) of the Act states "* * * with respect to *a hospital*, the highest resident level for any of the three most recent cost reporting periods (ending before the date of enactment of this paragraph) *of the hospital* for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary" (emphasis added). Therefore, if *a hospital* has a reference resident level below its otherwise applicable resident limit during its reference cost reporting period, then that hospital will receive a cap reduction, even if the affiliated group as a group is not training at a level below its aggregate otherwise applicable resident limit. In addition, the statute requires the Secretary to take "*the* highest resident level" (emphasis added) from the applicable reference period, and compare that level to the hospital's otherwise applicable resident limit. The statute does not include language that expressly states that if a hospital is training below its otherwise applicable resident limit during its reference cost reporting period, the Secretary shall look to the two other cost reporting periods to determine whether the hospital is training at or above its cap in either of those two other cost reporting periods. We believe that if Congress had intended a hospital to be exempt from a cap reduction if it is training at or above its cap in any of its three most recent cost reporting periods, it would have included specific statutory language instructing the Secretary that once the determination is made as to which cost reporting period is the cost reporting period with the highest FTE resident count, a determination must also be made as to whether the hospital is training at or above its cap in any of its three most recent cost reporting periods.

We believe there may be confusion as to the use of the terms "otherwise applicable resident limit" and "reference resident level." We are clarifying that "otherwise applicable resident limit" generally refers to a hospital's 1996 FTE cap adjusted for the scenarios described earlier in this preamble (including a hospital's participation in Medicare GME affiliated group) and for any cap reductions made under section 422 of Public Law 108–173 in a *specific* cost reporting period. The reference resident level refers to a hospital's highest resident level (the highest FTE resident count) for any of the three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been settled, or if not, submitted (subject to audit), as determined by the Secretary. We disagree with the commenter who stated that the proposed definition of "reference resident level" for purposes of section 5503 of the Affordable Care Act includes the correct word "any," and therefore the preamble discussion is not consistent with the definition. The commenter is referring to the proposed definition of reference resident level at § 413.79(c)(1)(ii)(B), which stated "[f]or purpose of paragraph (m) of this section, *reference resident level* means with respect to a hospital, the highest resident level for any of the three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been either settled or submitted (subject to audit)." We do not believe this definition is inconsistent with our preamble discussion regarding cap reductions under section 1886(h)(8)(A) of the Act. The proposed definition at § 413.79(c)(1)(ii)(B) includes the same use of the word "any," as the definition of reference resident level at section 1886(h)(8)(H)(i) of the Act, which states " * * * with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting period * * *" The use of the word "any" is referring to the instruction that the Secretary is to use the one cost reporting period with the highest resident level (highest FTE resident count) from any of the hospital's three most recent cost reporting periods ending before March 23, 2010 which have been settled or if not, submitted, subject to audit. The use of the word "any" in the proposed definition at § 413.79(c)(1)(ii)(B) does not infer that if a hospital is training FTE residents at or above its FTE resident cap in any of the

three most recent cost reporting periods, that it would be exempt from a cap reduction. Rather, we specifically included in the proposed regulation text at § 413.79(m)(4) the following: "[a] hospital training at or above its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section for all three most recent cost reporting periods ending prior to March 23, 2010 (as described under section (iv) of this paragraph), is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section." Therefore, if a hospital is training at or above its caps in each (that is, all) of its three most recent cost reporting periods used to determine the hospital's reference resident level, it would be exempt from a cap reduction.

In response to the commenter's concern that previously the Provider Reimbursement Manual provided guidance for auditors and that, in recent years, Medicare has substituted instructions in the Provider Reimbursement Manual with preamble language, we intend to issue additional instructions to Medicare contractors that will provide further instructions regarding the implementation of section 1886(h)(8) of the Act. Additionally, we encourage Medicare contractors to contact us if they have questions regarding the situation of a specific hospital.

Comment: One commenter stated that, as is probably true for other academic medical centers, it has experienced a number of changes over time concerning the GME programs it sponsors. For the commenter, these changes have resulted in a reduction in the number of FTE residents it is training from its 1996 base year. The commenter stated that its affiliations with other institutions also have changed; specifically, it had previously affiliated with an institution in Maryland but is currently in its third year of participating in a Medicare GME affiliation agreement with an institution in Virginia. The commenter stated that, because of this history, it is concerned with the way that CMS is proposing to implement section 5503 of the Affordable Care Act and that the proposed calculation of the otherwise applicable resident limit may result in an unnecessary reduction to its FTE cap. The commenter believed that the three cost reporting periods used to determine its reference cost reporting periods would be FYEs June 30, 2007, June 30, 2008, and June 30, 2009; however, its Medicare GME affiliation agreement has only been in place for the July 1, 2008–June 30, 2009 cost reporting period. The commenter believed that this period is its period with the highest FTE resident count. However, the commenter indicated that it realizes that, through the unpredictable audit process, the June 30, 2007 FYE or June 30, 2008 FYE could become the reference cost reporting period. Therefore, the commenter believed it is possible that the hospital's reference cost reporting period could be a cost reporting period in which it was participating in a Medicare GME affiliated group under which the cap reduction would be higher than if it was based on a cost reporting period where there was the smallest difference between the cap and the count. The commenter stated "[a]lthough CMS has proposed that there be a 'matching' of the year used to determine both the reference resident level and the otherwise applicable resident limit, governing legal authority does not compel such a policy." The commenter stated that, in the proposed rule, CMS inferred that the data used to determine the reference resident level and the otherwise applicable resident limit are to come from the same cost reporting period. The commenter believed that if a hospital entered into a Medicare GME affiliation agreement in the cost reporting period with the highest FTE resident count, the hospital's adjusted cap would be used to determine a cap reduction but if the hospital did not participate in a Medicare GME affiliated group during that year, its unadjusted cap would be used to determine the cap reduction. The commenter stated that if the hospital is not participating in a Medicare GME affiliated group, its unadjusted cap would be used even if the hospital participated in a Medicare GME affiliated group in one of the other two cost reporting periods, which resulted in a smaller difference between the cap and the count. The commenter stated CMS did not include the rationale for such a policy in the proposed rule. The commenter presented several options for CMS to consider regarding how to calculate cap reductions under section 5503.

The commenter stated that one alternative would be to determine whether a hospital should receive a cap reduction using the year in which there is the least amount of difference between the cap and the count. The commenter stated that although the statute defines the "reference resident level" as "the highest resident level for any of the 3 most recent cost reporting periods," "the literal wording of the statute is at odds with its manifest intent." The commenter stated that Congress' goal in using the highest FTE resident count included in the three most recent cost reporting periods ending before March 23, 2010, is to make sure hospitals receive the minimum cap reduction reasonable based on recent data. The commenter asserted that because the literal reading of the statute is at odds with its "manifest intent," CMS is permitted and expected to interpret the statute in a manner that more closely reflects its purpose. The commenter referenced the court case in *American Water Works Association* v. *Environmental Protection Agency* (40 F.3d 1266, 1271 (D.C. Cir. 1994). The commenter described this case as "deferring to the agency, which prioritized a statute's overarching intent over its literal wording, where that wording would have led to 'absurd results.'"

The commenter offered a second option under which CMS could finalize a policy in which the otherwise applicable resident limit would be determined to be the lowest FTE cap from any of the three most recent cost reporting periods ending prior to March 23, 2010. The commenter stated that Congress was silent on which year should be used to determine the otherwise applicable resident limit; therefore, CMS has the discretion to decide which year to use for this limit. The commenter stated "CMS can, however, glean congressional intent from the definition of reference resident level, which relies on a 3-year look-back to properly protect hospitals from excessive FTE cap reductions. Using the lowest FTE cap of the prior three years would therefore appropriately mirror the reference resident level provisions."

The commenter gave a third option under which CMS could use the FTE cap that a hospital had on the date of enactment to determine whether a hospital should receive a cap reduction. In describing this option, the commenter referred to the court case in *Johnson* v. *United States* (529 U.S. 694, 702 (2000)). In reference to this case, the commenter stated "finding that the effective date for a statute, where Congress gives no clear direction, is the date of enactment." The commenter stated that, under this option, if a hospital was participating in a Medicare GME affiliation agreement on March 23, 2010, CMS could use the cap as adjusted per that affiliation agreement for purposes of determining whether a hospital should receive a cap reduction. The commenter indicated that, under this proposal, any amendments made to the Medicare GME affiliation agreement prior to July 1, 2010, could also be taken into account (because hospitals are able to amend their Medicare GME affiliation agreements through June 30 of the

academic year for which they are effective).

The final option suggested by the commenter was to consider a hospital's participation in a Medicare GME affiliated group if it was participating in a Medicare GME affiliation agreement either in the year the hospital had its highest FTE resident count or the date of enactment (March 23, 2010). The commenter suggested that if a hospital participated in a Medicare GME affiliated group in both years, CMS could use the lower of either of the two caps for determining whether the hospital should receive a cap reduction.

Response: We do not agree with the commenter's statement that although CMS proposed that the reference resident level and otherwise applicable resident limit come from the same cost reporting period, that legal authority does not require such a policy. We do not understand how comparing the FTE resident cap and FTE resident count from two separate cost reporting periods would provide for a valid comparison because both a hospital's FTE resident cap and its FTE resident count, for numerous reasons, could change from year to year and would not necessarily be a measure of excess capacity. Therefore, in this final rule, we are clarifying that the reference resident level and otherwise applicable resident level used to determine whether a hospital has any unused cap, must come from the same cost reporting period. As discussed later in this preamble, the cost reporting period that is used to determine whether a hospital will receive a cap reduction under section 5503 of the Affordable Care Act, must be based on a cost report that is settled or has been submitted to the Medicare contractor by March 23, 2010. In addition, the statute requires that the Secretary take "the highest resident level" from the applicable reference period, and compare that level to the hospital's otherwise applicable resident limit. The statute does not include language that would allow the Secretary to determine that the reference cost reporting period for hospitals is the cost reporting period where there is the least amount of difference between the FTE resident count and the cap.

Comment: One commenter stated that Congress' intent in specifying the use of the three most recent cost reporting periods was "to make it clear that it wanted CMS to consider the three most recent completed cost report years for which data would be available for each hospital prior to the enactment of the ACA." The commenter stated that this approach would ensure that CMS was working with the most up-to-date data so that inappropriate cap redistributions would not be made based on data from older cost reporting periods. The commenter stated there was some vagueness in the proposed rule regarding the application of cap reductions to hospitals that have a cost reporting period that corresponds to the calendar year. Specifically, the commenter indicated that there is a concern for the January 1, 2009 through December 31, 2009 cost reporting period because these providers would not be required to submit their cost report to their Medicare contractor until May 31, 2010.

Commenters requested that CMS confirm that its contractors will be directed to include the cost reporting period ending December 31, 2009 in their review of the three most recent cost reporting periods. One commenter specifically requested that a hospital with a fiscal year of January 1–December 31 be able to use its December 31, 2009 FYE cost reporting period as one of the hospital's three most recent cost reporting periods as long as the hospital has submitted its December 31, 2009 FYE cost report by the time the audit of the hospital's FTE count has taken place. Another commenter stated that the 3-year look-back period used to determine cap reductions may disadvantage those hospitals that attempted to fill unused FTE resident slots after the Affordable Care Act was enacted. The commenter stated that, while generally the 3-year look-back period would be acceptable, because of the timing of the enactment of the Affordable Care Act in late March, the end of resident recruitment in June 2010, and the date of issuance of the proposed rule, some hospitals, in an effort to preserve their FTE resident slots, may have interviewed and hired additional residents for their current academic year. The commenter requested that CMS include as part of the 3-year look-back period, the count of residents included in the current academic year, that is July 1, 2010–June 30, 2011, so that hospitals that acted as quickly as possible to fill their FTE slots, especially slots associated with primary care programs, are not penalized for their actions.

One commenter indicated that recent developments have caused a change in the number of residents training at its hospital; specifically, a realignment of affiliations has caused a decrease in the number of residents the medical school rotates to the hospital. However, in its efforts to meet the community's needs and provide high quality medical care, the commenter indicated that the hospital has established several new programs, is starting one new residency program this year, and is in the process of receiving accreditation for nine new programs, which will start in the next 5 years. The commenter stated that, as a member of one Medicare GME affiliated group, it reduced its caps for the benefit of the other participant in the affiliated group. In another instance, where the hospital accepted displaced residents as part of an emergency Medicare GME affiliation agreement, the commenter indicated that, in order to provide a seamless transition to a new training site, the hospital did not have an opportunity to verify in advance if it needed any additional residency positions under its FTE cap. The commenter believed that, within a year, its count will at least equal its 1996 caps, and given that its FTE count reduction was only temporary, any permanent reduction to its FTE caps would result in financial hardship which could cause the hospital to have to reduce its caps and would be detrimental to the community. The commenter asserted that in the statutory definition of reference resident level, the phrase "(ending before the date of enactment of this paragraph)" modifies the phrase "3 most recent cost reporting periods." The commenter stated the FYE December 31, 2009 cost reporting period would be included in this definition of reference resident level because the January 1, 2009 through December 31, 2009 cost reporting period ended prior to March 23, 2010. The commenter believed that even though the statutory language refers to cost reports being settled or at least submitted, these requirements do not need to occur prior to March 23, 2010. The commenter believed that, considering the literal wording of the statute, the only requirement that must have been met prior to March 23, 2010 is that the cost report must have ended, submission of and settling of the cost report must only occur prior to CMS' determination of reductions. The commenter stated that the interpretation of the language included in section 5503 outlined in its comment letter is similar to the interpretation made by CMS of the language included in section 422 of the MMA. The commenter included the following language which refers to the definition of "reference resident level" under section 422 of the MMA:

"[T]he reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before September 30, 2002, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary."

The commenter pointed out that CMS, in its proposed rulemaking, stated it would calculate the reduction in the number of FTE resident slots using the cost reporting period ending on or before September 30, 2002, using either a settled cost report or an as-submitted cost report, which would be subject to audit, and that CMS set a cut-off date of December 2005 as the date by which the cost report submission and audit would be completed. The commenter stated that, under section 422, there was no express cut-off date by which the reference cost report was required to be submitted, and there was certainly not a cut-off date of before September 30, 2002. The commenter stated that, for purposes of section 422, CMS' primary concern was timely audit of the cost report for the reference cost reporting period. The commenter asserted that a similar approach could be applied to using the cost reporting period January 1, 2009–December 31, 2009 to determine reductions under section 5503. The commenter stated that because CMS stated in the proposed rule that it expects decisions to be made about cap reductions by December 2011, Medicare contractors will have 19 months to review, audit, and finalize audit adjustments to cost reports for the January 1, 2009 through December 31, 2009 cost reporting period. The commenter believed that there is nothing preventing CMS from maintaining consistency with implementation of section 422 of the MMA by including the January 1, 2009–December 31, 2009 cost reporting period as a cost reporting period that can be used to determine a hospital's reference resident level.

Response: We do not agree that the cost reporting period of January 1, 2009–December 31, 2009 should be included in the group of the three cost reporting periods used to determine whether a hospital will receive a cap reduction under section 1886(h)(8)(A) of the Act. We believe that the cost reports used to determine whether a hospital will receive a cap reduction must, at the very least, have been submitted to the Medicare contractor as of March 23, 2010. Furthermore, we do not believe it would be appropriate to include in the determination of which cost reports are used to establish a hospital's reference resident level, those cost reporting periods that occurred at the time the Affordable Care Act was in development. Rather the cost reporting period used to determine the reference resident level should be a cost reporting period that reflects a number of FTE residents that a hospital is accustomed to training, not a number of FTE residents that is based on a hospital's rushed attempt to avoid a cap reduction. Therefore, we also disagree with the commenter who requested that CMS include, as part of the 3-year look-back period, the count of residents included in the July 1, 2010–June 30, 2011 academic year. Additionally, this cost reporting period does not end prior to March 23, 2010.

In response to the commenter who suggested that CMS follow a similar process for determining a hospital's reference resident level for purposes of section 5503 of the Affordable Care Act as it did for section 422 of the MMA, we note that the time period for implementing section 5503 of the Affordable Care Act is shorter than the time that was available to implement section 422 of the MMA. In general, the cost reporting period used to determine the reference resident level under section 422 was the most recent cost reporting period ending on or before September 30, 2002. Public Law 108–173, which included section 422, was enacted on December 8, 2003. Therefore, in general, the cost reports used to determine the reference resident level for section 422 had already been submitted at the time Public Law 108–173 was enacted. For purposes of section 5503 of the Affordable Care, a cost report for the cost reporting period January 1, 2009–December 31, 2009, would likely not have been submitted by March 23, 2010, the time section 5503 of the Affordable Care Act was enacted. Therefore, in this final rule, we are clarifying that the three most recent cost reports used to determine a hospital's reference resident level must be cost reports that, if not settled, have been submitted to the Medicare contractor by March 23, 2010. We also are clarifying our regulation text at § 413.79(c)(1)(ii)(B) to state: "For purposes of paragraph (m) of this section, *reference resident level* means with respect to a hospital, the highest resident level for any of the three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been either settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010." In addition, as we explain in response to comments below regarding the cost report data that must be submitted with a hospital's application for additional slots and the cost reports used to establish a hospital's primary care average under section 1886(h)(8)(B)(ii)(I) of the Act, these cost reports must also be submitted to the Medicare contractor by March 23, 2010.

Comment: Several commenters asked for clarification on the application of cap reductions to new teaching hospitals. The commenters believed that the final rule should clarify that hospitals which have had their cap established during the last three cost reporting periods ending prior to March 23, 2010, and those new teaching hospitals that do not yet have a cap established because they are in the middle of the three year cap building period should be exempt from any cap reduction. The commenters believed that these new teaching hospitals should not have their caps reduced under section 1886(h)(8)(A) of the Act because they are still in the process of building their residency training programs, especially those residency programs that have an initial residency period of longer than 3 years; therefore, these hospitals should not lose any cap which they are in the process of establishing.

Response: We agree with the commenters that new teaching hospitals should not have their caps reduced if the hospitals are still in the process of establishing their cap and that some new teaching hospitals may still be in the process of growing their new program(s), particularly if the new program(s) has an initial residency period of greater than 3 years. Because Congress specifically required the Secretary to consider three cost reporting periods to determine which cost reporting period would be the reference cost reporting period based on the period with the highest resident level, we do not believe it would be appropriate to consider whether a new teaching hospital, with less than three years of cap data, should receive a cap reduction. Therefore, we are clarifying in this final rule that those teaching hospitals that do not yet have a cap established for Medicare payment purposes because they are in the middle of their 3-year cap building period will be exempt from a cap reduction. Additionally, we understand the commenters' concerns regarding new teaching hospitals that have a cap established but are still in the process of growing their program because the initial residency period of the program is greater than 3 years. Therefore, after considering these comments, we are finalizing the policy that if a new teaching hospital has submitted cost reports for its three most recent cost reporting periods ending before March 23, 2010, by March 23, 2010, but a cap is not applied in *all three* of those cost reporting periods, the new teaching hospital would be exempt from a cap

reduction. For example, if a new teaching hospital submitted three cost reports by March 23, 2010, but a cap was only applied to the hospital in two of the three cost reports, the new teaching hospital would be exempt from a cap reduction. We are revising the regulations at § 413.79(m) to reflect this change.

Comment: One commenter stated there was nothing in the proposed rule that exempted a hospital located in Louisiana, which was devastated by Hurricane Katrina, from a cap reduction under section 1886(h)(8)(A) of the Act. The commenter stated that, as a result of the devastation to its facilities caused by Hurricane Katrina, the hospital loaned 300 of its 573 FTE cap slots to other facilities located mostly in the New Orleans area through emergency Medicare GME affiliation agreements. The commenter stated that its hospital is in the process of rebuilding, and if the facility's 300 FTE cap slots are not exempt from the resident redistribution, redistributing these slots to other hospitals would be devastating to the New Orleans area and to the facility's rebuilding process.

Response: The statute does not provide for a specific exemption from a cap reduction for those hospitals affected by Hurricane Katrina. However, we note that, in our discussion regarding cap increases under section 5503 of the Affordable Care Act, the State of Louisiana is indicated as a State that can apply for additional slots.

b. Audits of the Reference Cost Reporting Periods

As mentioned under XXI.D.8.a. of this preamble, to determine a possible reduction to a hospital's FTE resident cap, section 1886(h)(8)(H)(i) of the Act, as added by section 5503(a) of Affordable Care Act, directs the Secretary to use, as the reference cost report, the one cost report out of the hospital's three most recent cost reporting periods ending before March 23, 2010, with the highest resident count "for which a cost report has been *settled* (or, *if not, submitted (subject to audit*), as determined by the Secretary" (emphasis added). In the August 3, 2010 proposed rule (75 FR 46394 and 46395), we proposed that if a hospital's cost report for the reference cost reporting period has been settled, the hospital's settled cost report, without further audit, would be used to determine possible reductions to the FTE resident caps. We noted that the "settled" cost report does not necessarily mean the initial cost report settlement. The Medicare contractor may have previously settled the cost report, reopened it to audit it, and then settled the cost report again, issuing a revised NPR. Thus, we would refer to the most recently issued NPR for that cost reporting period (prior to March 23, 2010). For those cost reporting periods that would be used as the reference cost reporting period, which have been submitted to the Medicare contractor but not settled, Medicare contractors may perform desk or onsite audits related to section 5503. In addition, if the reference period cost report is for a period other than 12 months, we proposed that for direct GME, the Medicare contractor would prorate the FTE resident caps and unweighted FTE resident count to equal 12-month counts.

We did not receive public comments specific to this section. Therefore, we are finalizing the stated policy as proposed.

c. Medicare GME Affiliation Agreements

As described above, some hospitals that have resident levels below their FTE resident caps may have entered into Medicare GME affiliation agreements (as permitted under § 413.79(f) of our regulations) with other hospitals that would otherwise exceed their FTE resident caps. Thus, while some hospitals in the Medicare GME affiliated group were training a number of residents below their FTE resident caps prior to entering into a Medicare GME affiliation agreement, upon affiliating, their FTE resident caps were temporarily reduced because some or all of their excess FTE slots were temporarily added to the FTE resident caps of other hospitals as part of the affiliation agreement. Under section 422 of Public Law 108–173, the statute explicitly directed the Secretary to apply the provisions to hospitals that were members of the same affiliated group as of July 1, 2003. Specifically, section 1886(h)(7)(A)(iii) of the Act states "The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) as of July 1, 2003." Therefore, in implementing section 422, we based the FTE resident cap reductions for hospitals that were participating in a Medicare GME affiliated group on the aggregate cap and count data from all hospitals participating in the same Medicare GME affiliated group(s). If a hospital was training a number of residents below its FTE resident cap for the reference cost reporting period but the hospital was part of a Medicare GME affiliated group for some or all of that reference cost reporting period, the Medicare contractor determined if the aggregate affiliated count for all hospitals in the affiliated group was greater than the aggregate affiliated cap. If the aggregate affiliated count was greater than the aggregate cap, then there was no reduction made to the FTE caps of any hospital in the affiliated group (even for the hospital that was part of the affiliated group, but was training below its cap). However, we note that, in contrast to section 422 of Public Law 108–173, section 5503 of the Affordable Care Act does not include language specific to affiliated groups as was included in section 422 under section 1886(h)(7)(A)(iii) of the Act. Thus, section 5503 of the Affordable Care Act does not provide for determinations based on the aggregate experience of a Medicare GME affiliated group. In addition, section 1886(h)(8)(H) of the Act, as added by section 5503 of the Affordable Care Act, defines the reference resident level and the otherwise applicable resident limit with respect to "a hospital." Similarly, section 1886(h)(8)(A) of the Act refers only to "a hospital's" reference resident level. Therefore, we are determining whether a hospital should receive a cap reduction based on that individual hospital's experience and not the aggregate experience of the Medicare GME affiliated group. Therefore, in the August 3, 2010 proposed rule (75 FR 46395), we proposed that Medicare contractors would make determinations regarding FTE cap reductions under section 1886(h)(8)(A)(i) of the Act by considering the relationship of the individual hospital's otherwise applicable resident limit for the reference period (which is the FTE resident cap for a period as adjusted by any affiliation agreement(s)) to the individual hospital's reference resident level. That is, we proposed that in a hospital's reference year, if that hospital is participating in a Medicare GME affiliated group and is training a number of residents below its FTE caps as adjusted pursuant to any affiliation agreements which can be found on Worksheet E, Part A, line 3.06 for IME, and Worksheet E–3 Part IV, line 3.03 for direct GME, the hospital's FTE resident caps would be subject to a reduction under section 1886(h)(8)(A)(i) even if the Medicare GME affiliated group as a whole may be training a number of residents above the group's aggregate FTE resident cap.

Comment: Many commenters addressed the proposed policies regarding the treatment of affiliated groups in determining whether a hospital would receive a cap reduction

under section 1886(h)(8)(A) of the Act. Commenters supported the proposal to account for a hospital's participation in a Medicare GME affiliated group during its reference year. One commenter stated that, in finalizing the proposal to consider a hospital's participation in a Medicare GME affiliated group during its reference year, it will be important for the Secretary to recognize the hospital's cap as reduced due to participation in a Medicare GME affiliated group before comparing the hospital's count to its cap during the reference cost reporting year. Commenters disagreed with the proposal to not consider aggregated caps and counts of a Medicare GME affiliated group when determining if an individual hospital would receive a cap reduction. Commenters stated that if CMS does not consider affiliated groups as a whole when determining cap reductions, entire residency programs could be lost, each hospital participating in an affiliated group could be negatively affected, and training relationships could be damaged.

One commenter addressed the situation of a specific Medicare GME affiliated group. The commenter stated that a hospital in Iowa is receiving a temporary cap increase through participation in the Medicare GME affiliated group. The commenter asserted that if the hospital that is transferring cap receives a cap reduction, the existence of the entire residency program could be put in jeopardy because the residents may no longer be able to rotate to various sites. One commenter stated that the purpose of Medicare GME affiliation agreements is to allow for transfer of the cap to appropriate hospitals to provide residents with opportunities for additional training. The commenter believed that, in keeping with the spirit of the law, the resident level and limit should be calculated in aggregate for all hospitals participating in a Medicare GME affiliated group. Another commenter stated that hospitals that are complying with the regulations at § 413.75 should only receive cap reductions under section 5503 after looking at the aggregate affiliated cap. The commenter noted that it has sponsorship under the ACGME for programs at hospitals included in its affiliated group and that such sponsorship supports the position that hospitals' caps and counts should be looked at in the aggregate. The commenter stated that because CMS proposed to look at an individual hospital's cap as adjusted for any Medicare GME affiliation agreements, such a proposal indicates that CMS recognizes the potential impact affiliation agreements may have on hospitals' caps, and, therefore, CMS should apply the same policy for treatment of affiliated groups to section 5503 as it did for section 422 of the MMA. Other commenters also suggested CMS be consistent in its policies and follow the precedent set for treatment of Medicare GME affiliated groups under the implementation of section 422 of the MMA. Another commenter stated that affiliation agreements are intended to provide stability and address changes in rotations and programs for participating hospitals and that CMS should make sure that FTE caps are not unintentionally removed from an affiliated group.

Many commenters stated that redistributing slots used through a Medicare GME affiliation agreement was not the intent of Congress. Rather, the commenters believed that Congress' intent was only to redistribute those slots which are "unused." The commenters stated that if the affiliated group as a whole is over its cap, the slots are clearly being used. One commenter stated that, in addressing the implementation of section 5503, Congress was certainly knowledgeable about the common practice of hospitals participating in Medicare GME affiliation agreements to "share" FTE slots to maximize the training of residents and of the FTE slots. The commenter stated "Under any common language meaning of the term 'unused,' FTE cap slots that are shared among hospitals in GME affiliated groups would not be considered 'unused positions.'" Some commenters noted that they plan to work to correct the statutory problem of not considering the aggregated caps and counts of hospitals participating in a Medicare GME affiliated group. Commenters stated that, although they appreciated that CMS is using adjusted cap numbers in situations where hospitals share cap through a Medicare GME affiliated group, the initial cap and count comparison should be made at the affiliated group level. The commenters stated that performing an initial comparison of the affiliated group's cap and count is supported by the statutory definition of "otherwise applicable resident limit" included in the Affordable Care Act, which states:

"The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A)."

The commenters also referred to language from paragraph (h)(4)(H) of section 1886 of the Act:

"(ii) Aggregation—The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis."

The commenters believed that because CMS has the authority to "prescribe rules" concerning GME affiliated groups, CMS has the authority to view the affiliated group as a whole for purposes of determining cap reductions under section 1886(h)(8)(A) of the Act.

One commenter recommended that CMS finalize a policy for treatment of affiliated groups such that in the case where the aggregate count is above the aggregate cap in any of the 3 years, none of the hospitals participating in the Medicare GME affiliated group would receive a cap reduction. The commenter stated "* * * that surprising and counterintuitive outcomes may result when CMS attempts to compare an individual hospital's affiliated cap and count for just one year and then apply that result to the individual hospital's unaffiliated cap." The commenter noted there have been situations where agreements to provide for educational rotations among hospitals have "worked to the (permanent) detriment of a hospital when reduction determinations have been made." Therefore, the commenter believed that it is important for CMS to include safeguards such that inappropriate redistributions do not occur when reducing the caps of individual hospitals. The commenter believed that because Congress went out of its way to provide CMS with the opportunity to review 3 separate years instead of just 1 year for purposes of cap reductions under section 1886(h)(8)(A) of the Act, the intent of Congress was to clarify that if a hospital is training above its cap in *any* of its three most recent cost reporting periods, the hospital should not receive a cap reduction. The commenter noted that if a hospital's cap changes during the 3 years, for example through participation in a Medicare GME affiliated group, only considering the 1 year with the highest resident count "may cause different kinds of results for individual hospitals." The commenter suggested that, to determine whether a hospital should receive a cap reduction, the policy be that if a hospital is participating in a Medicare GME affiliated group, the year that is used to determine a cap reduction is the

year where there is the smallest gap between the aggregate cap and the aggregate count.

One commenter stated that if two hospitals participate in a Medicare GME affiliated group, under the proposed rule, these hospitals may be penalized for their participation because one hospital is going to be training residents over its cap while the other hospital is going to be training residents under its cap. The commenter gave an example where hospital A and hospital B are participating in a Medicare GME affiliated group and hospital A's cap prior to the affiliation was 50 and hospital B's cap prior to the affiliation agreement was 100. Under the commenter's example, hospital A transfers 10 cap slots to hospital B for FYEs 2006–2008 such that during the affiliation agreements, hospital A's FTE resident count is 40 and hospital B's FTE resident count is 110. The commenter stated that during the Medicare GME affiliation agreement, the aggregate count is 150 and the aggregate cap is 150, but based on CMS' proposed rule, hospital A's cap would be reduced by 6.5 FTEs. The commenter questioned why hospitals should be penalized if they enter into Medicare GME affiliated groups and maintained an aggregate count that is the same as the aggregate cap. Another commenter stated that many teaching hospitals affiliated with colleges of osteopathic medicine train residents in rural and underserved areas and that even though rural hospitals with fewer than 250 beds may be exempt from a cap reduction, those hospitals may be negatively impacted if the hospitals with which they affiliate have their caps reduced. The commenter stated that reducing the caps of hospitals with which these rural hospitals are affiliated could limit access to patient care in areas where these providers are needed to provide care. The commenter requested that CMS reconsider its policy regarding cap reductions so that areas served by osteopathic training programs that are in greatest need of physicians are not limited.

Commenters reasoned that if a hospital is participating in a Medicare GME affiliated group and is training below its cap, the hospital that is receiving the temporary cap adjustment through the Medicare GME affiliation agreement would be the facility that receives a cap reduction and not the hospital that loaned slots through the Medicare GME affiliation agreement. The commenters requested clarification on this assumption. One commenter stated that not considering the affiliated group as a whole could potentially lead to not recapturing all of the unused cap slots in the situation where a hospital without a 1996 cap and without a new program cap is part of a GME affiliated group due to a shared rotational arrangement. The commenter stated, "If the hospital's FTE count exceeded its cap affiliation adjustment, the hospital has no 1996 cap or new program cap that could be reduced to effect a cap recapture."

One commenter requested that, for purposes of the cap redistribution under section 5503 of the Affordable Care Act, CMS take into consideration the shared rotational agreement its hospital has had with another hospital since 1993 ("1993 Agreement"), even though the shared rotational agreement did not comply with the requirements of a Medicare GME affiliated group until July 1, 2009. The commenter suggested that, in the alternative, if CMS does not consider the shared rotational arrangement that has been in place between the two hospitals since 1993, CMS at the very least maintain the status quo by considering the fact that these two hospitals have in place fully compliant Medicare GME affiliation agreements for academic years July 1, 2009 through June 30, 2011, which reflect the hospitals' longstanding practice of rotating the residents between the two facilities. The commenter stated that if CMS does not change its proposed rule as presented in the comment, one of the hospitals participating in the shared rotational arrangement will be subject to a large cap reduction, which in turn will place the longstanding training relationship between the two hospitals at risk. The commenter stated that one of the hospitals that participates in the shared rotational arrangement and the county jointly sponsor about 54 primary care and subspecialty residency training programs, and approximately 900 residents participate in these programs, with 500 of these residents also training at the second hospital participating in the shared rotational arrangement. The commenter stated that both hospitals serve a broad demographic of patients throughout the State of California, and both offer specialized and advanced services that provide residents with a variety of educational opportunities. The commenter stated that the "1993 Agreement" provided for a "bilateral exchange" of residents, and that, without this exchange, certain ACGME opportunities would not be available because the hospitals offer different services. The commenter stated that the sending hospital employs the residents but the receiving hospital is financially responsible for the cost of the residents' salaries and fringe benefits for the time that the residents spend at the receiving hospital. The commenter stated that the "1993 Agreement" was in place before direct GME and IME caps or the concept of a Medicare GME affiliation agreement, and although it does not meet all the regulatory requirements of a Medicare GME affiliation agreement, it has been in place for more than 17 years, including what will be one of the hospital's reference periods. The commenter stated that because the "1993 Agreement" did not include all the elements of a Medicare GME affiliation agreement, one of the hospitals was not eligible to receive payment for about half of the 90 FTEs it trained in FYEs May 31, 2007 through May 31, 2009. However, the commenter stated this problem was mostly corrected when both facilities entered into a Medicare GME affiliation agreement effective with the July 1, 2009 training year. The commenter stated that the analysis applied to the cap reductions "* * * should focus on *use* of the FTE slots and whether, in practice and pursuant to a written agreement that is akin to a Medicare GME affiliation agreement, the hospitals were transferring FTEs." The commenter stated that the legislative history does not indicate that Congress wanted to disturb existing training relationships or not provide for payment where there were, in fact, residents providing care to Medicare beneficiaries but rather the purpose of section 1886(h)(8) of the Act is to transfer FTE slots from facilities that are not providing training to those that are. The commenter stated that CMS could view the hospitals' situation one of two ways, either that the FTE slots that went to the receiving hospital were slots that were in use by the sending hospital, or that the hospitals had in place a shared rotational arrangement that basically complied with the requirements of a Medicare GME affiliation agreement and under these circumstances the sending hospital's cap was reduced by 70 or 80 FTEs through the transfer agreement. The commenter stated that, under either approach, the hospital that has been sending its FTE residents to the second facility is not presumed to have an extra gap of 70 to 80 FTEs between its reference resident level and its otherwise applicable resident limit because those 70 or 80 FTEs were being used at the receiving facility and being used pursuant to a written affiliation agreement. The commenter stated that if CMS chooses not to take into account the shared rotational agreement between the two hospitals and that the agreement

was in effect during the reference period, then, at the very least, CMS should preserve the current status quo based on the Medicare GME affiliation agreement in place during the current and prior academic years. The commenter indicated that, given the July 1, 2009–June 30, 2010 Medicare GME affiliation agreement was executed well before Congress authored the Affordable Care Act and covers part of one of the hospital's fiscal year ending before March 2010, CMS should take this agreement into account when determining which hospitals will receive cap reductions. The commenter also noted the two hospitals have entered into a Medicare GME affiliation agreement effective July 1, 2010 through June 30, 2011, which transfers the same number of FTEs as the July 1, 2009–June 30, 2010 Medicare GME affiliation agreement. The commenter stated that the Medicare GME affiliation agreement that is in place now will renew automatically and will continue unless CMS redistributes the slots. The commenter stated that, in addition to considering the formal FTE cap adjustments that make changes to hospitals' cost report worksheets on Worksheets E, Part A and E–3 Part IV, CMS could also consider shared rotational agreements that had the same effect. The commenter also stated that CMS could require, as part of the audit process, that providers submit to their Medicare contractor relevant written agreements and documentation regarding the exact number of FTEs exchanged between the two hospitals.

Response: We appreciate the commenters' support of the proposed policy to account for an individual hospital's participation in a Medicare GME affiliated group for purposes of determining that hospital's otherwise applicable resident limit. In response to the commenters who stated CMS should apply the same policy for determining whether a hospital that is participating in a Medicare GME affiliated group would receive a cap reduction, as was applied for purposes of implementing section 422, specific statutory language was included in section 422, which referred to Medicare GME affiliations. Section 422 amended section 1886(h) of the Act, by adding paragraph (7)(A)(iii) which stated "[t]he provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined under paragraph (4)(H)(ii)) as of July 1, 2003." Neither this same statutory language nor similar language addressing Medicare GME affiliated groups was included in section 5503 of the Affordable Care Act. As we stated in the proposed rule, the definition of "otherwise applicable resident limit" does not include language that can support a policy allowing Medicare contractors to look at the Medicare GME affiliated group in the aggregate before determining whether an individual hospital would receive a cap reduction based on its participation in the affiliated group. Rather, in the definition of "otherwise applicable resident limit" in section 5503, the statute refers to "a hospital." Although the commenters noted that the definition of "otherwise applicable resident limit" refers to section 1886(h)(4)(H) of the Act, which includes at paragraph (ii) the following language: "[t]he Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis," the reference made to prescribing rules for Medicare GME affiliation agreements refers to developing regulations to implement how each hospital's cap can be adjusted for its participation in a Medicare GME affiliated group. The language at section 1886(h)(4)(H)(ii) of the Act does not give the Secretary the authority to prescribe rules for treatment of Medicare GME affiliated groups under section 1886(h)(8)(A) of the Act. Furthermore, section 1886(h)(4)(H)(ii) of the Act was not amended after implementation of section 422 to provide the Secretary with the authority to prescribe specific rules for the treatment of Medicare GME affiliated groups for purposes of determining cap reductions under section 422. The lack of amendments made to section 1886(h)(4)(H) of the Act as a result of section 422 is further evidence that the reference to section 1886(h)(4)(H) of the Act in the definition of "otherwise applicable resident limit" under section 5503 is not intended to give the Secretary the authority to prescribe specific rules for the treatment of Medicare GME affiliated groups under section 5503 by mention of section 1886(h)(4)(H)(ii) of the Act. Rather, the reference to section 1886(h)(4)(h)(ii) of the Act is to require the Secretary to consider the hospital's cap *after* any adjustment agreed to in an affiliation agreement in determining the hospital's "otherwise applicable resident limit." To do otherwise, in a situation where a hospital has "affiliated away" some of its slots and trained up to its revised cap, would force the hospital to lose some of its "excess," even though in the year of the affiliation after reducing its cap in the affiliation, it had no excess.

In response to the commenter who stated that, under the proposed rule, if two hospitals are participating in a Medicare GME affiliated group, one hospital would be penalized for its participation because one hospital would be training below its cap and the other hospital would be training above its cap, we stated in the proposed rule that a hospital's otherwise applicable resident limit would generally be its 1996 cap adjusted for several criteria, including a hospital's participation in a Medicare GME affiliation agreement. Therefore, if a hospital's cap is temporarily reduced because it is transferring some of its cap slots to another hospital as part of a Medicare GME affiliation agreement, the hospital must only be concerned with a cap reduction if during its reference cost reporting period its reference resident level is below its adjusted cap, "the otherwise applicable resident limit." In the commenter's example, hospital A and hospital B are participating in a Medicare GME affiliated group and have caps of 50 and 100, respectively. As part of the Medicare GME affiliation, hospital A transfers 10 cap slots to hospital B so that for purposes of the Medicare GME affiliated group, hospital A's adjusted cap is 40 and hospital B's adjusted cap is 110. If hospital A and hospital B are participating in this Medicare GME affiliated group during their reference cost reporting period, hospital A would only have to be concerned with a cap reduction if its highest FTE resident count in its reference cost reporting period was less than 40 and hospital B would only have to be concerned with a cap reduction if its highest FTE resident count in its reference cost report was less than 110.

In response to the commenter who stated that, even though rural hospitals with fewer than 250 beds would be exempt from a cap reduction under section 1886(h)(8)(A) of the Act, those hospitals would be negatively affected if the hospital(s) with which they affiliate have their caps reduced, we appreciate the commenter's concern to ensure that access to care is not limited in rural and underserved areas as a result of section 5503. However, section 1886(h)(8)(A) of the Act does not provide for a specific exemption for urban hospitals that participate in Medicare GME affiliated groups with rural hospitals with fewer than 250 beds. We note that the application for receiving cap slots under section 1886(h)(8) of the Act includes the following Evaluation Criterion, which specifically addresses residency training in rural areas: The hospital is in a rural area (as defined under section

1886(d)(2)(D)(ii) of the Act) and is or will be on or after July 1, 2011, a training site for a rural track residency program (as specified under § 413.79(k)), but is unable to count all of the FTE residents training in the rural track because the rural hospital's FTE cap is lower than its unweighted count of allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011. Furthermore, we note that, under the regulations at § 413.79(e)(1)(iii) a rural hospital can always receive a permanent cap adjustment for training residents in a new residency training program.

In response to the commenter who asked for clarification as to whether, if a hospital received FTE cap slots through participation in a Medicare GME affiliated group but was training below its cap adjusted under the Medicare GME affiliation agreement during its reference cost reporting period, we are clarifying that the hospital that received the cap slots or the hospital that loaned the cap slots would receive a cap reduction, the hospital that received the slots but is training below its adjusted cap would receive a cap reduction. The hospital that is transferring some of its FTE cap slots would not be penalized if the hospital to which it temporarily transferred some of its FTE cap slots is training below its adjusted cap during its reference cost reporting period.

In response to the commenter who stated "If the hospital's FTE count exceeded its cap affiliation adjustment, the hospital has no 1996 cap or new program cap that could be reduced to effect a cap recapture," in describing a hospital that has no 1996 cap or new program cap but receives cap slots as part of a Medicare GME affiliation agreement, we believe the commenter meant to describe the scenario as one in which a hospital does not have a 1996 cap or a new program cap and receives a temporary cap adjustment as part of a Medicare GME affiliated group but is training below its affiliated cap during its reference cost reporting period. Under this scenario, the commenter is correct that there would be no cap to recapture because the hospital does not have a base year cap to reduce. Rather, it only has a temporary cap due to its participation in the Medicare GME affiliated group, and section 1886(h)(8)(A) of the Act does not provide for the Secretary to look at a Medicare GME affiliated group as a whole for purposes of determining individual hospitals' cap reductions.

In response to the commenter who requested that CMS either take into consideration the shared rotational agreement it has had since 1993 with another hospital or maintain the status quo by considering the fact that these two hospitals have in place a fully compliant Medicare GME affiliation agreements for academic years July 1, 2009 through June 30, 2011, which reflect the hospitals' longstanding practice of rotating the residents between the two facilities, we appreciate the commenter's interest in maintaining its current level of training at its facilities. However, section 1886(h)(8)(A) of the Act does not provide the Secretary with the authority to provide an exception for these specific scenarios. Therefore, if either one of the hospitals participating in the shared rotational arrangement is training below its official adjusted cap during its reference cost reporting period, it would receive a cap reduction. The fact that the hospitals acted as if they had an affiliation agreement, as required by the regulations, is not a sufficient basis for revising the hospitals' caps.

After consideration of the public comments we received, we are finalizing our policy regarding treatment of Medicare GME affiliated groups as proposed. Specifically, we are finalizing our policy to state that, in a hospital's reference cost reporting period, if the hospital is participating in a Medicare GME affiliated group and is training a number of residents below its FTE caps, as adjusted under any affiliation agreements that can be found on Worksheet E, Part A, line 3.06 for IME, and Worksheet E–3 Part IV, line 3.03 for direct GME, the hospital's FTE resident caps would be subject to a reduction under section 1886(h)(8)(A)(i) of the Act, even if the Medicare GME affiliated group as a whole may be training a number of residents above the group's aggregate FTE resident cap.

d. Treatment of Hospitals That Have Merged

We note that there may be instances where two hospitals merge on or after March 23, 2010, but were not merged in any or all of their three most recent cost reporting periods ending before March 23, 2010. For these hospitals, in the August 3, 2010 proposed rule (75 FR 46395), we proposed that the Medicare contractors identify the hospitals' three most recent cost reporting periods ending before March 23, 2010, and treat the hospitals for purposes of section 1886(h)(8)(A)(i) of the Act as if they were merged during those periods in determining whether there should be a reduction to the merged facility's FTE resident cap(s). That is, we proposed that, for each of the 3 years, we would combine the FTE resident counts and caps of the formerly separate facilities in order to identify the reference period, and to calculate the reference resident level and the otherwise applicable resident limit for the merged facility (for IME and direct GME, respectively), even if the two facilities have different fiscal year ends. In addition, if any of the cost reporting periods are less than 12 months or greater than 13 months, the Medicare contractor would prorate the FTE resident counts and FTE caps for direct GME to equal a 12-month cost reporting period.

Comment: One commenter requested that hospitals that merged be allowed to use different cost reporting periods in determining whether the merged facility will receive an FTE cap reduction. The commenter stated that, for hospitals that have merged, the year with the highest reference resident level may not be the same year for all of the hospitals. The commenter believed that, to ensure there is the smallest reduction in hospitals' resident caps, the Secretary should permit different cost reporting periods to be used (as long as all of the years are within the periods contemplated by section 5003) when the hospital's FTE counts and caps are combined to determine whether the merged facility should receive a cap reduction. The commenter further believed that the final rule should address the treatment of hospitals that merged during the three most recent cost reporting periods ending before March 23, 2010. Commenters stated that the same policy that was proposed for hospitals that merge on or after March 23, 2010, should apply to hospitals that merged prior to March 23, 2010, as long as the merger occurred in any of the three most recent cost reporting periods ending before March 23, 2010.

Response: Although we had proposed to apply the proposed policy to hospitals that had merged on or after March 23, 2010, after consideration of the public comments we received, we believe the policy does not need to be applied to hospitals that merge on or after March 23, 2010. In fact, where two hospitals have three separate cost reporting periods that can be used to determine the hospitals' reference resident levels, we will determine the highest reference resident level and the otherwise applicable resident limit for each hospital separately, and then combine the determinations of any excess to apply to the merged hospitals, effective July 1, 2011. However, where for either 1 or 2 of the 3 years used to determine the reference resident level, the hospitals had merged, it will be necessary to determine 3 years of data

as if those hospitals had merged during all of those 3 years. In this final rule, we are revising the policy to reflect these changes.

9. Application of Section 5503 to Hospitals That File Low Utilization Medicare Cost Reports

In general, section 5503 of the Affordable Care Act applies to Medicare-participating hospitals that train residents in approved residency training programs. However, some Medicare-participating hospitals may choose to submit low utilization cost reports. These low utilization cost reports may not contain the cost report worksheet that is used to calculate payments for direct GME, Worksheet E–3 Part IV. That is, these cost reports may not contain FTE resident count and cap information. For example, because Medicare-participating children's hospitals primarily serve a non-Medicare population and, therefore, receive minimal Medicare payments, some teaching children's hospitals submit low utilization cost reports. If a children's hospital files a low utilization cost report in a given cost reporting period, and does not file the Worksheet E–3 Part IV, that hospital has no data to determine its reference resident level. In addition, although children's hospitals may have an FTE resident "cap" that is applicable for purposes of the Children's Hospital Graduate Medical Education (CHGME) Payment Program, administered by HRSA, this cap is not necessarily used for Medicare payment purposes. Therefore, in the August 3, 2010 proposed rule (75 FR 46395), we proposed that if a low utilization hospital does not have a cap for Medicare payment purposes, it would not be subject to a negative cap reduction under section 5503. In addition, we proposed that if a low utilization hospital does have a cap for Medicare payment purposes (for example, it had filed a regular cost report in 1996) but did *not* file Worksheet E–3 Part IV as part of its cost report in *all* of its three most recent cost reporting periods ending before March 23, 2010, it would be exempt from cap reduction. In addition, we proposed that if a low utilization hospital has a cap for Medicare payment purposes and filed Worksheet E–3 Part IV in at least one of its three most recent cost reports ending before March 23, 2010, the Medicare contractor would determine, based on the data of the available cost reports with Worksheet E–3 Part IV, whether a cap reduction is necessary under section 1886(h)(8)(A)(i) of the Act.

For those low utilization hospitals that have an FTE cap for Medicare payment purposes and have filed Worksheet E–3 Part IV in any of the three most recent cost reporting periods ending before March 23, 2010, we proposed that in determining whether, and by how much, that low utilization hospital's cap may be reduced, we would use the same methodology that we proposed to use for other Medicare-participating teaching hospitals. In addition, for purposes of section 1886(h)(8)(B) of the Act, we proposed that a low utilization hospital would be eligible to apply for an increase in its FTE resident cap under section 1886(h)(8)(B) of the Act, subject to the same demonstrated likelihood and evaluation criteria proposed for all other hospitals. However, as explained further below in this preamble, section 1886(h)(8)(B)(ii) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, specifies certain requirements and thresholds that a hospital that receives additional slots must meet in order to retain those slots. One requirement is that the hospital must ensure that, for a 5-year period, its number of FTE primary care residents is not less than the average number of FTE primary care residents during the three most recent cost reporting periods ending prior to March 23, 2010. Accordingly, in the August 3, 2010 proposed rule (75 FR 46396), we proposed that an applying children's hospital must meet the same documentation requirements to establish this primary care average as other applying hospitals, which would mean that the children's hospital must have submitted a Worksheet E–3, Part IV with its Medicare cost report for those three most recent cost reporting periods ending prior to March 23, 2010. Furthermore, we proposed that, in order to receive an increase in its FTE resident cap under section 1886(h)(8)(B) of the Act, effective July 1, 2011, in addition to complying with the proposed application requirements as described in this preamble, the hospital would be required to file Worksheet E–3, Part IV, with its Medicare cost report for its cost reporting period that includes July 1, 2011, through and including its cost reporting period that includes June 30, 2016 (that is, the 5-year period). We proposed that the low utilization hospital must meet this requirement because section 1886(h)(8)(B) of the Act is intended to allow a hospital to increase its FTE counts for purposes of Medicare GME payments. We do not believe it would be appropriate to grant an increase in a hospital's FTE resident cap under section 1886(h)(8)(B) of the Act if the hospital does not use the slots for Medicare purposes (but only, for example, for purposes of the CHGME Payment Program) as would be evidenced by not filing a Worksheet E–3, Part IV. Moreover, as explained further below, we are required under sections 1886(h)(8)(B)(ii) and 1886(h)(8)(B)(iii) of the Act to ensure certain levels of primary care or general surgery training, and the information in Worksheet E–3, Part IV, would be necessary for that purpose.

Comment: Commenters supported the proposed policy that if a low utilization hospital does not have a cap for Medicare payment purposes or did not file Worksheet E–3, Part IV, in any of its three most recent cost reporting periods ending before March 23, 2010, it would be exempt from a cap reduction. One commenter encouraged CMS to consider the differences in the patients that children's hospitals serve as well as the unique relationship children's hospitals have with both the Medicare GME and CHGME programs as CMS makes decisions about redistribution of slots. Specifically, the commenter recommended that low or no-filer children's hospitals that meet all the other criteria should be eligible to apply for additional slots even if they have not submitted Worksheet E–3, Part IV over the past 3 years, as this will allow children's hospitals the opportunity to expand primary care and general surgery programs.

Response: We thank the commenters for their support of the proposed policy. In this final rule, we are finalizing a policy regarding low utilization hospitals such that if a low utilization hospital does not have a cap for Medicare payment purposes or did not file Worksheet E–3, Part IV for any of its three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been settled or submitted to the Medicare contractor by March 23, 2010, that low utilization hospital would be exempt from a cap reduction. We are finalizing the policy that if a low utilization hospital has a cap for Medicare payment purposes and filed Worksheet E–3, Part IV in at least one of its three most recent cost reports ending before March 23, 2010, for which a cost report has been settled or has been submitted to the Medicare contractor by March 23, 2010, the Medicare contractor would determine, based on the data of the available cost reports with Worksheet E–3, Part IV, whether a cap reduction is necessary under section 1886(h)(8)(A)(i) of the Act. For purposes of section 1886(h)(8)(B) of the Act, we proposed that a low utilization hospital would be eligible to apply for an increase in its FTE resident cap under section

1886(h)(8)(B) of the Act, subject to the same demonstrated likelihood and evaluation criteria proposed for all other hospitals. As explained further in this preamble, section 1886(h)(8)(B)(ii) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, specifies certain requirements and thresholds that a hospital that receives additional slots must meet in order to retain those slots. One requirement is that the hospital must ensure for a 5-year period that its number of FTE primary care residents is not less than the average number of FTE primary care residents during the three most recent cost reporting periods ending prior to March 23, 2010.

In response to the commenter's recommendation that low or no filer children's hospitals that meet all the other criteria should be eligible to apply for additional slots even if they had not submitted Worksheet E–3, Part IV over the past 3 years, we are changing our proposed policy in this final rule to allow a low utilization hospital to be eligible to apply for an increase in its FTE resident cap if it submitted by March 23, 2010, at least one cost report (instead of three cost reports) that includes Worksheet E–3, Part IV for cost reporting periods ending prior to March 23, 2010. Therefore, in determining whether, in its 5-year period of July 1, 2011 through June 30, 2016, the hospital's number of primary care residents is not less than a baseline amount, that baseline amount must include at least one cost report that includes Worksheet E–3, Part IV for a cost reporting period ending prior to March 23, 2010, that was submitted by March 23, 2010. If the low utilization hospital submits more than one cost report, the baseline amount will be based on an average of those cost reports (up to 3 years). In addition, we proposed a general requirement that all applicants must submit copies of their most recent as filed Worksheet E–3, Part IV for direct GME, Worksheet E, Part A for IME (which would not apply for children's hospitals), and if the hospital received slots under section 422 of the MMA, Worksheet E–3, Part VI as well (75 FR 46399 and 46420). In this final rule, as explained further below, under the Demonstrated Likelihood Criteria, applicants are also required to submit copies of these same worksheets from the cost report that was most recently submitted to the Medicare contractor by March 23, 2010. Secondly, we proposed that, in order to receive an increase in its FTE resident cap under section 1886(h)(8)(B) of the Act, effective July 1, 2011, in addition to complying with the proposed application requirements as described in this preamble, the hospital must file Worksheet E–3, Part IV, with its Medicare cost report for cost reporting periods that include July 1, 2011, through and including its cost reporting period that includes June 30, 2016 (that is, the 5-year period). In this final rule, we are finalizing these requirements for low utilization hospitals, without modification, and we are clarifying that a cost report or reports that would be used to determine whether a low utilization hospital would receive a cap reduction, would be a cost report that has been settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010.

10. Treatment of Hospitals with Caps That Have Been Reduced or Increased Under Section 422 of Public Law 108–173

For purposes of implementation of section 5503(a) of the Affordable Care Act, section 1886(h)(8)(H)(iii) of the Act states that the term "otherwise applicable resident limit," means, "with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A)." As noted earlier in this preamble, section 1886(h)(7)(A) of the Act, as added by section 422 of Public Law 108–173, provided for reductions to hospitals' caps if the hospitals were training a number of residents below their FTE resident caps during the relevant reference period, and for a "redistribution" that increased the FTE resident caps for certain hospitals. Although sections 1886(h)(4)(F)(i) and 1886(h)(4)(H) of the Act refer to paragraph (7), which includes both cap reductions and increases made pursuant to section 422 of Public Law 108–173, we believe that specific mention of only paragraph (7)(A), which refers to cap reductions made under section 422, gives the Secretary the authority to only take into account the reductions made to hospitals' caps under section 1886(h)(7)(A) of the Act, for purposes of implementing section 1886(h)(8)(A)(i) of the Act. That is, we believe specific mention of paragraph (7)(A) is meant to provide that in determining a hospital's otherwise applicable resident limit, the Secretary should take into account any reductions to its reference resident level made under section 1886(h)(7)(A) of the Act to determine whether a cap reduction under section 1886(h)(8)(A)(i) of the Act is necessary. Furthermore, section 1886(h)(8)(H)(i) of the Act requires that, for purposes of determining the reference resident level, the Secretary is required to consider the hospital's three most recent cost reporting periods ending prior to March 23, 2010, that have been settled (or, if not, submitted (subject to audit)), as determined by the Secretary. In addition, we note that increases made under section 1886(h)(7)(B) of the Act were effective for portions of cost reporting periods beginning on or after July 1, 2005, and that some hospitals may still be filling their residency training programs with FTE resident slots gained under section 1886(h)(7)(B) of the Act, during what may be their reference cost reporting period for purposes of section 1886(h)(8)(A)(i) of the Act. Therefore, we believe that it would be inappropriate to include increases made under section 1886(h)(7)(B) of the Act in determining the hospital's reference resident level for purposes of cap reductions under section 1886(h)(8)(A)(i) of the Act. Hospitals that received increases to their caps under section 1886(h)(7)(B) of the Act may still be "building" their residency programs using the additional FTE resident slots they received under section 1886(h)(7)(B) of the Act. Therefore, it would be premature to remove any of those FTE resident slots. Accordingly, in the August 3, 2010 proposed rule (75 FR 46396), we proposed that, in determining whether a cap reduction is necessary under section 1886(h)(8)(A)(i) of the Act, we would compare the hospital's FTE resident count for its reference period to its FTE resident cap, as adjusted under section 1886(h)(7)(A) of the Act. We proposed that we would not consider any increases to its resident cap a hospital may have received under section 1886(h)(7) of the Act.

Comment: Commenters supported the proposed policy to compare a hospital's reference resident level to its cap as reduced under section 422 for purposes of determining whether the hospital should receive a cap reduction. One commenter requested that CMS confirm that its reference in the proposed §§ 412.105(f)(iv)(B)(2) and (C)(2) to paragraph "(f)(1)(E)(iv)(B)(1)" is a typographical error and the reference should be to paragraph "(f)(1)(iv)(B)(1)."

Response: The commenter is correct that we made a typographical error and the cross-reference in § 412.105(f)(iv)(B)(2) should be changed from paragraph "(f)(1)(E)(iv)(B)(1)" to paragraph "(f)(1)(iv)(B)(1)." We are not making any reference to paragraph (f)(1)(iv)(B)(1) in § 412.105(f)(1)(iv)(C)(2) because it is possible that a hospital may not have received a cap reduction either under section 1886(h)(7)(A) or section 1886(h)(8)(A) of the Act. We are

making these corrections to the regulations in this final rule. We appreciate the commenters' support of our proposed policy regarding treatment of hospitals' caps as reduced under section 422. We are finalizing our treatment of hospitals' caps as reduced under section 422 as proposed.

11. Criteria for Determining Hospitals That Will Receive Increases in Their FTE Resident Caps

Generally, under section 1886(h)(8)(A) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, the Secretary is to reduce the FTE resident caps for hospitals that were training a number of residents below their otherwise applicable resident limit in the reference period by 65 percent of the "excess" resident slots. Under section 1886(h)(8)(B) of the Act, the Secretary is to "redistribute" the estimated number of FTE reductions under section 1886(h)(8)(A) of the Act to increase the FTE resident caps for use by other hospitals. Under section 1886(h)(8)(B)(i) of the Act, the Secretary is authorized to increase the otherwise applicable FTE resident cap for each qualifying hospital that submits a timely application by a number that the Secretary may approve, for portions of cost reporting periods occurring on or after July 1, 2011. In implementing section 1886(h)(8)(B) of the Act, we note the difficulty in deciding how to prioritize hospitals' requests when redistributing unused resident slots. Therefore, in addition to some considerations and priorities in redistribution that are specified in section 5503 of the Affordable Care Act, in the August 3, 2010 proposed rule (75 FR 46396), we proposed certain additional criteria that we believe would allow for an objective decision-making process.

Section 1886(h)(8)(B) of the Act, as added by section 5503 of the Affordable Care Act, establishes certain parameters in the statutory language for hospitals to meet to qualify to receive increases in their FTE resident caps. First, section 1886(h)(8)(B)(i) of the Act states that the aggregate number of increases in the otherwise applicable resident limits (caps) shall be equal to the aggregate reduction in the resident limits determined under section 1886(h)(8)(A) of the Act as estimated by the Secretary (as discussed in section XXI.D. of this preamble). Section 1886(h)(8)(F) of the Act states that in no case will any hospital receive an FTE cap increase of more than 75 FTE positions as a result of the redistribution. In addition, section 1886(h)(8)(C) of the Act specifies that, in determining which hospitals will receive the increases to their FTE resident caps, the Secretary is required to take into account the demonstrated likelihood that the hospital would be able to fill the position(s) within the first three cost reporting periods beginning on or after July 1, 2011, and whether the hospital has an accredited rural training track program.

In setting up an application process for hospitals to apply for FTE resident cap increases from the redistribution pool (discussed in section XXI.D.12. of this preamble), in the August 3, 2010 proposed rule (75 FR 46397), we proposed to consider the "demonstrated likelihood" criterion under section 1886(h)(8)(C)(i) as an eligibility criterion that a hospital must meet in order for CMS to further consider the hospital's application for an increase in its FTE resident cap. We proposed that a hospital would meet the "demonstrated likelihood" criterion by demonstrating that it is either already training a number of FTE residents at or in excess of its current FTE caps (IME and direct GME FTE caps, respectively, *including any applicable section 422 cap add-on*), or that it does not have sufficient room under its current FTE caps to accommodate a planned new program or expansion of an existing program. We indicated that we believe it is appropriate to consider a hospital's "demonstrated likelihood" as a requirement because we believe such hospitals will be best positioned to make immediate and efficient use of any FTE cap increase, and thereby, to use any resulting increase in Medicare GME payments to train the physician workforce that will provide care to Medicare beneficiaries. Thus, we proposed that, in order to be eligible for consideration for an increase under section 1886(h)(8)(B) of the Act, a hospital must first demonstrate the likelihood that it will able to fill the slots within the first three cost reporting periods beginning on or after July 1, 2011, by meeting *at least one* of the following three criteria and by providing documentation that it meets the criterion in its application for an increase to its FTE resident cap:

• *Demonstrated Likelihood Criterion 1.* The hospital does not have sufficient room under its current FTE cap for a new residency program that it intends to establish on or after July 1, 2011 (that is, a newly approved program that begins training residents at any point within the hospital's first three cost reporting periods beginning on or after July 1, 2011). Under this criterion, the hospital would select one of the following:

(1) Hospital will establish a newly approved residency program. (Under this selection, the hospital would be required to check at least one of the following, if applicable):

☐ Application for approval of the new residency program has been submitted to the ACGME, AOA, or the ABMS by December 1, 2010. (The hospital would be required to attach a copy.)

☐ The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program by December 1, 2010. (The hospital would be required to attach a copy.)

☐ The hospital has received written correspondence from the ACGME, AOA, or ABMS acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). (The hospital would be required to attach a copy.)

(2) Hospital will likely fill the slots requested. (The hospital would be required to select at least one of the following, if applicable.)

☐ The hospital does not have sufficient room under its FTE cap, and the hospital's existing residency programs had a combined resident fill rate of at least 85 percent in each of program years 2007 through 2009. (The hospital would be required to attach documentation.)

☐ The hospital does not have sufficient room under its FTE cap, and the specialty program for which the hospital is applying has a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. (The hospital would be required to attach documentation.)

• *Demonstrated Likelihood Criterion 2.* The hospital does not have sufficient room under its FTE cap, and the hospital intends to use the additional FTEs to expand an existing residency training program within the hospital's first three cost reporting periods beginning on or after July 1, 2011.

(1) Hospital intends to expand an existing program. Under this selection, the hospital would be required to check at least one of the following, if applicable:

☐ The appropriate accrediting body (the ACGME, AOA, or ABMS) has approved the hospital's expansion of the number of FTE residents in the program. (The hospital would be required to attach documentation.)

☐ The American Osteopathic Association Residency Match Program

has accepted or will be accepting the hospital's participation in the match for the existing program that will include additional resident slots in that residency training program. (The hospital would be required to attach documentation.)

□ The hospital has submitted an institutional review document or program information form for the expansion of the existing residency training program by December 1, 2010. (The hospital would be required to attach documentation.)

(2) Hospital will likely fill the slots of the expanded existing residency program. Under this selection, the hospital would be required to check at least one of the following, if applicable:

□ The hospital does not have sufficient room under its FTE cap, and the hospital has other previously established residency programs, with a resident fill rate of at least 85 percent in each of program years 2007 through 2009.) (The hospital would be required to attach documentation.)

□ The hospital does not have sufficient room under its FTE cap, and the hospital is expanding an existing program in a particular specialty with a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. (The hospital would be required to attach documentation.)

• *Demonstrated Likelihood Criterion 3.* The hospital is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both. The hospital would be required to attach copies of each of the following:

—Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor on or by July 1, 2010, documenting on Worksheet E, Part A, Worksheet E–3, Part IV, and Worksheet E–3, Part VI, the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

—Copies of the 2010 residency match information concerning the number of residents at the hospital in its existing programs (that is, all programs, not only the ones for which the hospital may be requesting more slots).

—Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

In the August 3, 2010 proposed rule, we proposed that *each* hospital applying for an increase under section 1886(h)(8)(B)(i) of the Act would be required to meet at least one of the above criteria in order to demonstrate the likelihood that it will be able to fill the additional slots associated with any increase in the hospital's FTE resident cap within the first three cost reporting periods beginning on or after July 1, 2011. In other words, each hospital that wishes to apply for an increase in its FTE resident cap, as a preliminary matter, would be required to meet the "demonstrated likelihood" criterion in order for CMS to further consider the hospital's application for an increase in its FTE resident cap.

Although a hospital might be applying for additional slots for more than one specialty program, each application by a hospital must be program-specific. That is, the hospital would be required to complete a separate CMS evaluation form for each program and to demonstrate the likelihood of filling the slots in each program. However, in accordance with our general policy with respect to FTE resident caps, increases in hospital's FTE resident caps under section 1886(h)(8)(B)(i) of the Act for direct GME and IME, once granted to a hospital, would no longer be program-specific. Rather, the hospital's adjusted FTE resident caps would be applied to the hospital's FTE resident counts, including any residents the hospital trains. However, we noted, that for FTE residents counted as a result of an increase in the FTE resident caps under section 422 of Public Law 108–173, payment is calculated separately for direct GME purposes using the national average PRA and, for IME purposes using a multiplier of 0.66. If a hospital receives an increase to its FTE resident cap(s) under section 5503 of the Affordable Care Act, and also received a cap increase under section 422, we proposed that the hospital would first assess whether it is training a number of residents in excess of its combined 1996 FTE and section 5503 caps and, only if its number of FTE residents still exceeds this combined cap would the separate 422 payment rates be applied to the excess FTEs for IME and direct GME respectively. Nevertheless, while the slots a hospital would receive under section 1886(h)(8)(B)(i) of the Act for direct GME and IME, once granted to a hospital, would no longer be program-specific, the hospital that receives the slots must comply with the requirements specified at section 1886(h)(8)(B)(ii) of the Act for a 5-year period; that is, maintaining the primary care average and the 75-percent threshold. In addition, we note that because of the 75-percent threshold, a hospital cannot apply for slots under section 5503 only for a non-primary care program (other than general surgery). However, a hospital could apply for slots, and demonstrate that it needs 75 percent of those slots to start or expand a particular primary care (or general surgery) program, and that it needs 25 percent of those slots for use in a particular nonprimary care program. However, the hospital's request for each program will be evaluated separately. The hospital's request for slots to start or expand a particular primary care (or general surgery) program could receive some points under the Evaluation Criteria, and may be fulfilled, while the hospital's request for slots for use in a non-primary care program would not receive any points and would be ranked last after all other applications for primary care or general surgery programs. For example, a hospital could apply for a total of 4 slots; 3, or 75 percent, for use in starting a geriatrics fellowship program (5 points under Evaluation Criterion Two), and 1, or 25 percent, to be used to add a Vascular & Interventional Radiology fellow (0 points). The hospital would likely be awarded three slots for geriatrics, but the chances that it would also be rewarded one slot for the Vascular & Interventional Radiology fellow are very slim, as the request for this program would be ranked last after all requests for primary care or general surgery programs.

For purposes of the application for the increase to the FTE caps under section 1886(h)(8)(B)(i) of the Act, we proposed to define "national fill rate" for each academic year, as we did when implementing section 422 of Public Law 108–173. That is, we defined "national fill rate" as the number of residents training in a program nationally as compared to the number of accredited slots in that program as of June 30 of that year. This information is available from the ACGME and the AOA. Furthermore, we proposed to require that, for the purposes of an application for an increase to a hospital's FTE resident cap under section 1886(h)(8)(B) of the Act, a hospital must use the "fill rate" for the most recent academic year for which data are available.

We understand that hospitals may train fewer residents than the number of available accredited slots in their approved programs due to reasons other than an inability to fill those slots. Furthermore, because we understand that a national fill rate is not necessarily the only indicator of the ability of hospitals to fill residency positions in its CBSA or State, and there may be

characteristics particular to a region, such as population density, variety of practice settings, or access to technology or procedures that may allow a specified area to have a fill rate in a specific program that exceeds the program's national fill rate, we proposed several options for a hospital to satisfy the "fill rate'" criterion. In part, as when implementing section 422 of Public Law 108–173, we specified that the fill rate "threshold" is 85 percent. We believe that this rate will reasonably identify those programs that are likely to fill FTE resident positions in newly approved or expanded programs (while providing some latitude to account for other factors that affect the national fill rate), and to fully utilize an increase in FTE resident cap slots that may be available under section 1886(h)(8)(B) of the Act as added by section 5503 of the Affordable Care Act. We proposed that a hospital may demonstrate the likelihood of filling FTE resident positions associated with a possible increase in its FTE resident cap under section 5503 by documenting that any of the following applies to the new program or to an expansion of an existing program:

- The specialty program has a resident fill rate nationally, across all hospitals, of at least 85 percent.
- The specialty program has a resident fill rate within the State in which the hospital is located of at least 85 percent.
- If the hospital is located within an urban CBSA, the specialty program has a resident fill rate within the CBSA of at least 85 percent.

For the purposes of demonstrating the likelihood of filling FTE resident positions under section 1886(h)(8)(C)(i) of the Act, as added by section 5503, we proposed that "national fill rate" means, for the most recent academic year for which data is available, the number of residents training in a program nationally (combined allopathic and osteopathic residents) compared to the number of accredited slots in that program nationally as of June 30 of that year. The proposed Demonstrated Likelihood Criterion 1 and Demonstrated Likelihood Criterion 2 also allow a hospital to demonstrate the likelihood of filling the requested slots by demonstrating that the hospital's existing residency programs had a "resident fill rate" of at least 85 percent in each program year from 2007 through 2009. For the purpose of fulfilling these demonstrated likelihood criteria, we proposed to define "resident fill rate" to mean, for the most recent academic year for which data is available, the number of residents training in each program in total at a particular hospital as compared to the number of accredited slots in each program in total at that hospital as of June 30 of that year.

We also understand that, for certain programs, because of the length of the accreditation process and a relatively long match period, a hospital may be unable to accept its first class of PGY–1 residents until July 1, 2012. In the August 3, 2010 proposed rule (75 FR 46398 through 46399), we proposed that the hospital may still apply to receive a full complement of residents for the 3 years beginning July 1, 2012, assuming the applicant hospital can demonstrate the likelihood that it will fill the slots relating to a possible increase in its FTE resident caps under section 1886(h)(8)(B)(i). However, if the applicant hospital does not demonstrate the likelihood that it will fill *any* FTE slots for programs described by the hospital on the CMS evaluation form(s) at *any* point within the hospital's first three cost reporting periods beginning on or after July 1, 2011, the hospital would not be eligible for further consideration by CMS of an increase to the hospital's FTE caps under section 1886(h)(8)(B)(i). Accordingly, our proposed Demonstrated Likelihood Criterion 1 would reflect that the hospital does not have sufficient room under its FTE cap to train residents in a newly approved residency program that it demonstrates it will establish within the hospital's first three cost reporting periods beginning on or after July 1, 2011 (that is, a newly approved program that begins training residents *at any point within the hospital's first three cost reporting periods beginning on or after July 1, 2011*)" (emphasis added).

Under Demonstrated Likelihood Criterion 3, we proposed to allow a hospital that is already training a number of FTE residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both, to meet the demonstrated likelihood requirement. In order to document that it meets this criterion, a hospital would be required to submit copies of the 2010 "residency match" information concerning the number of residents the hospital has in an existing program. We believed the most recent match information could indicate that the hospital is expected to take in more residents than the number of cap slots it has available. For purposes of the application of this demonstrated likelihood criterion, we proposed to define "residency match" as a national process administered by the National Residency Matching Program (NRMP), including the NRMP's Specialties Matching Service, the San Francisco Matching Program, the American Osteopathic Association Residency Match Program, or the Urology Matching Program, by which applicants to approved medical residency programs are paired with programs on the basis of preferences expressed by both the applicants and the program directors. (We note that in this final rule, we removed Demonstrated Likelihood Criterion 3).

We also noted in the proposed rule that under Demonstrated Likelihood Criteria 2 and 3, the hospital would be applying for an increase in its FTE cap because it is expanding an *existing* residency program, or it is already training residents in an *existing* residency training program(s) in excess of its FTE caps, respectively. By existing program, we proposed that, as of July 1, 2010, the hospital is either already training residents in this program or programs, or the program exists at another hospital prior to July 1, 2011, but the residents begin to rotate at the applying hospital on or after July 1, 2011. We set forth several proposed methods for hospitals to be able to demonstrate to CMS under the proposed Demonstrated Likelihood Criterion 1 that they can fill the slots by showing CMS that they are establishing a *new* residency program on or after July 1, 2011. We believe hospitals that establish new residency programs *before* July 1, 2011, could possibly also meet Demonstrated Likelihood Criterion 2, relating to a hospital that is expanding an existing residency program on or after July 1, 2011. From the perspective of applying for the cap increase under section 1886(h)(8)(B)(i) of the Act, the new program that starts training residents in 2010 is an "existing residency program" because it began before July 1, 2011, and it is "expanding" if that program is increasing the number of FTE residents in the first three cost reporting periods beginning on or after July 1, 2011.

We noted that the listing of programs participating in the AOA Match Program will be available on the National Matching Services Web site as of November 1, 2010. Therefore, we proposed that programs utilizing the AOA Match Program may, in addition to the two options listed above, demonstrate the intent to expand an existing program by documenting that the AOA has accepted the hospital's participation in the match program by the December 1, 2010 application deadline. Therefore, we proposed that this method of demonstrating the hospital's intent to expand an existing program would be applicable for

programs participating in the AOA Match Program.

Comment: One commenter requested that CMS clarify that "Demonstrated Likelihood Criterion 3" applies both to hospitals at their cap as well as to those training residents "in excess of" their cap. The commenter noted that on page 46397 of the proposed rule, CMS states that a hospital may meet this demonstrated likelihood criterion "by demonstrating that it is [ ] already training a number of FTE residents at or in excess of its current FTE caps;" however, the longer description of "Demonstrated Likelihood Criterion 3" on page 46398 states that a hospital "is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both."

Another commenter thought that hospitals that are currently exceeding their caps should qualify to receive additional cap slots even without adding a new program or expanding an existing program. The commenter stated that CMS' explanation of the application of the "75 percent" test makes it appear that it is impossible to obtain increases to the caps without either starting or expanding a program. The commenter believed that there are inconsistencies in the preamble that permit a hospital that is over its cap to meet the "Demonstrated Likelihood" criteria without adding or expanding a program, and the point criteria which do not make adding or expanding a program essential, and the 75 percent test which cannot be satisfied without adding or expanding a program.

Response: After reading these comments and reviewing the proposed Demonstrated Likelihood Criteria 1, 2, and 3, we agree that clarification and revision of the criteria are necessary. Specifically, we are revising Demonstrated Likelihood Criteria 1 to incorporate the point that a hospital is applying for additional cap slots because it is *either* already exceeding its FTE cap, *or* it does not have sufficient room under its FTE cap to start a new program. For Demonstrated Likelihood Criterion 2, we are incorporating the point that a hospital is applying for additional cap slots because it is *either* already exceeding its FTE cap, *or* it does not have sufficient room under its FTE cap to expand an existing program. Thus, Demonstrated Likelihood Criteria 1 and 2 may apply to a hospital that may or may not already be exceeding its FTE cap, but it definitely plans on starting a new or expanding an existing program. Because we are specifying in this final rule that Demonstrated Likelihood Criteria 1 and 2 may also apply for hospitals that are in excess of their caps (albeit not solely for cap relief), we are adding that hospitals applying under these criteria could also submit copies of their Medicare cost report worksheets, documenting that they are in excess of their caps. However, in this final rule, instead of stating that the hospital must submit a copy of the Medicare cost report that has been most recently submitted to the Medicare contractor by July 1, 2010, as we stated in the proposed rule, we are stating that the hospital must submit a copy of the Medicare cost report that has been most recently submitted to the Medicare contractor on or before March 23, 2010, documenting on Worksheet E, Part A, Worksheet E–3, Part IV, and Worksheet E–3, Part VI, the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods. We are *removing* the proposed Demonstrated Likelihood Criterion 3 from this final rule because it is duplicative. Further, it has confused the commenters and has led some to believe that hospitals that are already training residents in excess of their caps, and are seeking the additional slots for cap relief, rather than for the purpose of starting a new or expanding an existing program, may apply for slots under section 5503. Since the intent of section 5503 is to *increase* the number of primary care or general surgery physicians by providing Medicare funding for new primary care or general surgery positions (either through establishment of new programs or expansions of existing programs), as the 75 percent requirement indicates, it would be inconsistent with this intent to provide funding for already existing positions. Thus, if hospitals are willing to increase the number of primary care or general surgery residents they are training above current levels, there may be some funding available under section 5503 for them to do so. Accordingly, we are clarifying that a hospital may not request additional slots under section 5503 solely for the purpose of cap relief. We explain in great detail below in response to comments regarding the primary care average requirement and the 75 percent threshold requirement how a hospital that is exceeding its FTE caps and that applies for additional slots would have to increase the number of residents it is training in order to meet the 75 percent threshold requirement. We refer readers to those comments and responses below.

With regard to the commenter's belief that there are inconsistencies in the preamble that permit a hospital that is over its cap to meet the "Demonstrated Likelihood" criteria without adding or expanding a program, and the Evaluation Criteria which do not make adding or expanding a program essential, we have reviewed the Evaluation Criteria and we believe that proposed Evaluation Criteria Two, Three, and Four specifically state that the "hospital will use the additional slots to establish a new or expand an existing program." This implies that the hospital intends to create new positions, rather than only seeking cap relief for existing positions. Proposed Evaluation Criteria One, Five, and Six are specific to the hospital's situation, rather than its particular programs, and they can be used in addition to Evaluation Criteria Two, Three, and Four. Therefore, we do not agree that there are inconsistencies between the proposed (or final) Demonstrated Likelihood Criteria and Evaluation Criteria.

Comment: One commenter agreed with CMS' proposal that one way of demonstrating the likelihood of filling slots awarded under section 5503 is for a hospital to show that it is already training residents in excess of its cap, but thought that the documentation requirements for such a hospital is "excessive." The commenter found it to be "particularly perplexing" that "*three* pieces of documentation would be required for a criterion that is the most straightforward rationale for requesting additional cap slots." The three pieces are (1) copies of most recent Medicare cost reports, documenting the DGME and IME caps, (2) copies of the 2010 residency match information concerning the number of residents at the hospital in its existing programs (all programs—not just the programs for which the hospital is requesting additional slots), and (3) copies of the most recent accreditation letters on all of the hospital's training programs for which the hospital trains and counts residents for DGME and IME payments. The commenter did not see the need to submit 2010 residency match information, "because these data do not necessarily indicate the total number of residents training at an institution," and submission of accreditation information is also "unnecessary and burdensome, particularly for institutions with 75 or more residency and fellowship programs—which is not uncommon." The commenter urged CMS to adopt only the requirement that copies of the most recent Medicare cost reports be submitted for Demonstrated Likelihood Criterion 3, and at a minimum, this requirement should be the requirement

for hospitals that were over their caps in all of the past three cost reporting periods. Another commenter asked CMS to clarify which cost reporting periods will be used to determine whether a hospital is "currently" over its cap.

Response: As we explained in response to the previous comment, we are clarifying that a hospital may not request additional cap slots under section 5503 merely for cap relief. Furthermore, since we have consolidated Demonstrated Likelihood Criteria 1 and 2, we are removing Demonstrated Likelihood Criterion 3 and its attending documentation requirements that the commenter believed were overly burdensome from this final rule.

Comment: One commenter believed that CMS should include an exception for family medicine in the fill rate requirement and expanded need requirement for the Demonstrated Likelihood Criteria 1 and 2. The commenter argued that the accreditation process for family medicine is unique in that it allows for "leeway" in the number of residents allowed to be trained. The commenter stated that a program may increase its complement of residents by a "limited, yet unstated" number as long as it is justified in its next accreditation review or approval cycle and as such, a specific number would not be stated. For the same reasons, the commenter further asserted that the information on a family medicine accreditation letter for Demonstrated Likelihood Criterion 3 would be inappropriate.

This commenter also noted that CMS seems to switch from using fill rate data to match data in Demonstrated Likelihood Criterion 3. The commenter recommended that CMS use fill rate data because "match data is incomplete and inaccurate as an aid to determining a resident census."

Response: We note first that, as stated in response to previous comments, we have eliminated Demonstrated Likelihood Criterion 3 from this final rule. Second, we are unsure of the precise question that the commenter is asking. It appears that the commenter is stating that directors of family medicine programs need not request approval from the ACGME every time they want to expand an existing program by a "limited" number of unspecified positions, so long as the increase in resident positions is declared and explained at the next accreditation review. If we are understanding the commenter correctly, we think the commenter is asking that hospitals that are applying for additional slots for the purpose of using those slots for a family medicine program should not be required to submit to CMS applications for approval (or actual approvals) of new or expansions of existing family medicine programs to the ACGME, or copies of recent accreditation letters. However, we do not think we should make a special exception to the Demonstrated Likelihood Criteria for family medicine programs since we have heard of situations where hospitals have increased their number of residents training in various programs (not just family medicine) above the number of accredited slots without immediate approval of the increase and without repercussions from the ACGME. Furthermore, even if a hospital increases the number of residents in a particular residency program, and that increase is not significant enough to definitely require pre-approval from the ACGME, we believe that requiring hospitals to submit to CMS as part of the Demonstrated Likelihood requirements applications for approval to expand programs is appropriate in the context of applications for additional slots under section 5503. The statute requires hospitals to "demonstrate the likelihood" of filling the positions, and documents submitted to the ACGME either requesting approval of, or received from the ACGME showing approval of expansions of existing programs demonstrates a commitment on the part of the hospital to actually expand those programs. Furthermore, although the commenter asked for an exception for family medicine programs from Demonstrated Likelihood Criterion 1, which is applicable to hospitals seeking slots with which to start a new program (in addition to asking for an exception to Demonstrated Likelihood Criterion 2), we are skeptical that the ACGME would actually allow a hospital to start a brand new family medicine program, without any submission of documentation at all. Although we understand that there are instances where residents may begin training in a new program on July 1 of an academic year, and the ACGME may retroactively accredit that program a few months later, the hospital would certainly have submitted to the ACGME an institutional review document or program information form concerning the new program, and by such time as the hospital begins to train the residents, we would hope that the hospital would have received written correspondence from the ACGME acknowledging receipt of the application for the new program, and notification of a site visit, as described under the requirements for Demonstrated Likelihood Criterion 1. Therefore, we are not revising the documentation requirements under Demonstrated Likelihood Criteria 1 and 2 specifically for family medicine.

However, we do believe some revision can be made to the documentation requirements under Demonstrated Likelihood Criterion 1 to ease the burden on hospitals applying for slots under section 5503 for family medicine and other programs. Under the proposed Demonstrated Likelihood Criterion 1, a hospital could demonstrate that it would likely fill the slots in a new program by showing that it (1) already received approval from the ACGME, AOA, or ABMS, (2) has already submitted an institutional review document or program information form requesting approval for a new program, or (3) has received correspondence from the accrediting agencies acknowledging receipt of the application for the new program, or other types of communication regarding the approval process. We understand that completing the program information form can be a time-consuming and lengthy process, which may pose some challenges for hospitals to complete in a timely fashion and meet CMS' application deadline for receipt of slots under section 5503. Therefore, we are adding a fourth option under Demonstrated Likelihood Criterion 1 which we believe may make it easier for some hospitals to comply with this criterion. Specifically, we are adding that the hospital may submit documentation demonstrating that it has made a commitment to start a new program. One example of such a commitment would be for the hospital to provide the minutes from the meeting at which the hospital's GME committee gave approval for the hospital to proceed with the process of applying to the accrediting agency for approval to start a new program. We are not adding a similar option under Demonstrated Likelihood Criterion 2 because we understand that the process for requesting approval to expand an existing program is not as time-consuming and labor-intensive as the process for requesting approval for a brand new program.

We are revising and consolidating the Demonstrated Likelihood Criteria as follows:

- *Demonstrated Likelihood Criterion 1.* The hospital is training residents in excess of its FTE resident cap(s), or does not have sufficient room under its current FTE cap(s), and the hospital intends to use the additional FTEs for a new residency program that it intends to start on or after July 1, 2011 (that is, a newly approved program that begins training residents at any point within

the hospital's first three cost reporting periods beginning on or after July 1, 2011). Under this criterion, the hospital must select one of the following:

(1) Hospital will establish a newly approved residency program. (Under this selection, the hospital must check at least one of the following, if applicable):

☐ Application for approval of the new residency program has been submitted to the ACGME, AOA, or the ABMS by January 21, 2011. (The hospital must attach a copy.)

☐ The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program by January 21, 2011. (The hospital must attach a copy.)

☐ The hospital has received written correspondence from the ACGME, AOA, or ABMS acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). (The hospital must attach a copy.)

☐ The hospital may submit documentation demonstrating that it has made a commitment to start a new program.

(2) Hospital will likely fill the slots requested. (The hospital must select at least one of the following, if applicable.)

☐ The hospital does not have sufficient room under its FTE cap, or is exceeding its FTE cap, and the hospital's existing residency programs had a combined resident fill rate of at least 85 percent in each of program years 2007 through 2009. (The hospital must attach documentation.)

☐ The hospital does not have sufficient room under its FTE cap, or is exceeding its FTE cap, and the specialty program for which the hospital is applying has a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. (The hospital must attach documentation.)

☐ The hospital is training residents in excess of its direct GME FTE cap, or IME FTE cap, or both. The hospital must submit a copy of the Medicare cost report that has been most recently submitted to the Medicare contractor on or before January 21, 2011, documenting on Worksheet E, Part A, Worksheet E–3, Part IV, and Worksheet E–3, Part VI, the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

• *Demonstrated Likelihood Criterion 2.* The hospital is training residents in excess of its FTE cap(s), or does not have sufficient room under its FTE cap(s), and the hospital intends to use the additional FTEs to expand an existing residency training program within the hospital's first three cost reporting periods beginning on or after July 1, 2011.

(1) The hospital intends to expand an existing program. Under this selection, the hospital must check at least one of the following, if applicable:

☐ The appropriate accrediting body (the ACGME, AOA, or ABMS) has approved the hospital's expansion of the number of FTE residents in the program. (The hospital must attach documentation.)

☐ The American Osteopathic Association Residency Match Program has accepted or will be accepting the hospital's participation in the match for the existing program that will include additional resident slots in that residency training program. (The hospital must attach documentation.)

☐ The hospital has submitted an institutional review document or program information form for the expansion of the existing residency training program by January 21, 2011. (The hospital must attach documentation.)

(2) Hospital will likely fill the slots of the expanded existing residency program. Under this selection, the hospital must check at least one of the following, if applicable:

☐ The hospital does not have sufficient room under its FTE cap, or is exceeding its FTE cap, and the hospital has other previously established residency programs, with a resident fill rate of at least 85 percent in each of program years 2007 through 2009.) (The hospital must attach documentation.)

☐ The hospital does not have sufficient room under its FTE cap, or is exceeding its FTE cap, and the hospital is expanding an existing program in a particular specialty with a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. (The hospital must attach documentation.)

☐ The hospital is training residents in excess of its direct GME FTE cap, or IME FTE cap, or both. The hospital must submit a copy of the Medicare cost report that has been most recently submitted to the Medicare contractor by March 23, 2010, documenting on Worksheet E, Part A, Worksheet E–3, Part IV, and Worksheet E–3, Part VI, the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

Comment: One commenter requested that CMS allow hospitals to demonstrate their likelihood of using redistributed slots for three reporting periods beginning July 1, 2012, instead of July 1, 2011, as CMS has proposed. The commenter posited that by using the reporting period beginning July 1, 2012, hospitals would be able to document with greater precision their effective use of the redistributed slots.

Response: We understand that three cost reporting periods after a date of July 1, 2012, would give the commenters more time to demonstrate their effective use of the redistributed slots. However, we do not have any flexibility in choosing this date because section 1886(h)(8)(C) of the Act clearly specifies that the Secretary is required to take into account the demonstrated likelihood that a hospital would be able to fill the position(s) *within the first 3 cost reporting periods beginning on or after July 1, 2011.*

After consideration of the public comments we received, we are revising Demonstrated Likelihood Criteria 1 to incorporate the point that a hospital is applying for additional cap slots because it is *either* already exceeding its FTE cap, *or* it does not have sufficient room under its FTE cap and plans to start a new program. We also are revising Demonstrated Likelihood Criterion 1 to add that the hospital may submit documentation demonstrating that it has made a commitment to start a new program. For Demonstrated Likelihood Criterion 2, we are incorporating the point that a hospital is applying for additional cap slots because it is *either* already exceeding its FTE cap, *or* it does not have sufficient room under its FTE cap and it plans to expand an existing program. Thus, Demonstrated Likelihood Criteria 1 and 2 may apply to a hospital that may or may not already be exceeding its FTE cap, but it definitely plans on starting a new or expanding an existing program. Because we are specifying in this final rule that Demonstrated Likelihood Criteria 1 and 2 may also apply for hospitals that are in excess of their caps, we are adding that hospitals applying under these criteria must also submit copies of their Medicare cost report worksheets, documenting that they are in excess of their caps. Therefore, we are *removing* the proposed Demonstrated Likelihood Criterion 3 from this final rule because it is duplicative. Further, we are clarifying that because the intent of section 5503 is to *increase* the number of primary care or general surgery physicians by providing Medicare funding for new primary care or general surgery positions (either through establishment of new programs or expansions of existing programs),

hospitals may not apply to receive slots under section 5503 for the purpose of cap relief.

12. Application Process for the Increases in Hospitals' FTE Resident Caps

In order for hospitals to be considered for increases to their FTE resident caps under section 1886(h)(8)(B)(i) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, in the August 3, 2010 proposed rule (75 FR 46399), we proposed to require that each qualifying hospital submit a timely application by December 1, 2010. As part of the requirements that a hospital must fulfill in order to complete an application for an increase to its FTE resident caps, we proposed to require that the applicant hospital must include the total number of requested FTE resident slots (for all residency programs) for direct GME or IME, or both (not to exceed 75 FTEs for each, as specified under section 1886(h)(8)(F) of the Act). Thus, we would require that the hospital's total requests for increases in the IME and the direct GME caps (that is, the total number of requested FTE resident slots increases (for all residency programs at the hospitals)) would be required to be indicated on the same application for an increase under section 1886(h)(8)(B)(i) of the Act. We proposed that each hospital must submit the following information on its application for an increase in its FTE resident cap:

- The name and Medicare provider number of the hospital, and the name of the Medicare contractor to which the hospital submits its cost report.
- The total number of requested FTE resident slots (for all residency programs at the hospital) for direct GME or IME, or both (not to exceed 75 FTEs each).
- A completed copy of the CMS evaluation form (as described below) for each residency program for which the applicant hospital intends to use the requested increase in the number of FTE residents and source documentation to support the assertions made by the hospital on the evaluation form. (For example, if the hospital checks off on the evaluation form that the hospital is starting a new geriatrics program, the hospital would include documentation to support that assertion.)
- FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent as-filed cost report (as clarified in this final rule, submitted by March 23, 2010). (The hospital would be required to include copies of Worksheets E, Part A, E–3, Part IV, *and if a hospital received an increase to its FTE cap(s) under section 422 of Public Law 108–173,* a copy of Worksheet E–3, Part VI.)
- An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, of the following information in the hospital's application for an increase in its FTE resident cap:

"I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil, and administrative action, fines and/or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents."

We proposed that any hospital that wishes to apply for an increase in its FTE resident cap(s) under section 1886(h)(8)(B)(i) of the Act must submit a copy of its completed application (as described above) to the CMS Central Office and to the CMS Regional Office for the region in which the applicant hospital is located, and that the application must be received by CMS on or before December 1, 2010. (The mailing addresses for the CMS offices are indicated at the end of this section of the preamble.) We noted that some hospitals' FTE counts would be subject to audit for purposes of possible cap reductions under section 1886(h)(8)(A)(i) of the Act, and those audits may not be completed by December 1, 2010. Because the results of such an audit may be a factor in a hospital's decision whether to request an increase in its FTE resident cap under section 1886(h)(8)(B)(i) of the Act, we proposed to allow a later date for those hospitals to apply for increases in their FTE resident caps. Therefore, if a hospital's resident level is audited for purposes of section 1886(h)(8)(A) of the Act, whether or not the hospital's FTE resident caps are reduced under section 1886(h)(8)(A) of the Act, if that hospital wishes to apply for an increase in its FTE resident cap(s) available under section 1886(h)(8)(B)(i) of the Act, we proposed that the hospital must submit a completed application to CMS and that the application must be received on or before March 1, 2011.

We note that, although a hospital might be applying for an increase to its FTE caps either to start a new program or expand a particular program, the FTE caps are not program-specific; but rather, they are hospital-specific. A hospital, and not a particular residency training program, would be applying for an increase to its FTE caps. We proposed that all completed applications that are timely received according to the above deadlines would be evaluated by CMS according to the criteria described under section XXI.D.14. of this preamble for determining the priority distribution of FTE resident slots. Hospitals that satisfy at least one of the "demonstrated likelihood" criteria would be further evaluated by the evaluation criteria described below.

Comment: Commenters expressed concern regarding the proposed application deadline of December 1, 2010, for hospitals to apply for additional slots under section 5503. The commenters understand the short time frame CMS has to implement section 5503, but believe this deadline does not provide hospitals sufficient time after November 1, 2010, the date by which the final rule will be issued, to prepare their applications. The commenters noted that CMS proposed a second deadline of March 1, 2011, for certain hospitals that will be subject to an audit for purposes of determining a possible cap reduction, but those audits may not be completed by December 1, 2010. The commenters requested that CMS make March 1, 2011, the deadline for *all* hospitals to apply for slots under section 5503 since CMS would need to wait for the March 1 applications to be submitted before beginning the process of awarding slots anyway.

Response: While we agree with the commenters that more time is needed by hospitals after November 1, 2010, to review the final policies, gather documentation, and to submit the applications to CMS, we do not believe that it is necessary to extend the deadline to March 1, 2011 for all hospitals. Therefore, we are establishing the application deadline for hospitals requesting slots under section 5503 in this final rule to be Friday, January 21, 2011. However, if a hospital is notified that it will be audited for purposes of determining a possible cap reduction, such a hospital would be allowed to submit an application for additional cap slots by March 1, 2011.

Comment: One commenter urged CMS to reduce its proposed limit of 75 positions allowed for distribution to a single hospital in order to create opportunity for more institutions and more geographically diverse locations to meet requirements. The commenter

noted that it is highly likely that many of these positions would be used to sustain existing positions and, therefore, not meet the intent of the overall legislation. Additionally, the availability of positions in the environment must also be approved by the accrediting body that will have to evaluate the overall availability of teaching experiences and the impact on existing programs and existing complements of residents.

Response: As described in the August 3, 2010 proposed rule (75 FR 46390), section 5503 of the Affordable Care Act, which added a new section 1886(h)(8)(F) to the Act, specifically provides that a hospital may not receive more than 75 additional FTE slots under the section 5503 redistribution for direct GME and for IME, respectively. Therefore, a reduction to the limit of 75 positions for distribution to a single hospital is not authorized under the Affordable Care Act.

Comment: Another commenter noted that in order to be considered for increases to its FTE resident cap, a hospital must submit, as part of its application, its FTE resident counts and FTE resident caps for direct GME and IME in the most recent as-filed cost report. The commenter stated that if these worksheets are not audited, or at least reviewed by the Medicare contractor, there is no assurance of the accuracy of the number of FTE residents claimed by the provider. For consistency and accuracy purposes, the commenter recommended that the same source documents be used for determinations of both the increase and decrease in FTE caps, that is, a hospital's most recent cost report ending on or before March 23, 2010, which is subject to audit or desk review by the Medicare contractor.

Response: We agree that to the extent possible, the documentation used to determine whether a hospital's FTE resident caps will be reduced should be the same documentation used to determine whether a hospital qualifies for an increase in its FTE resident caps. As we stated above in response to a comment in section XXI.D.8.a. of this final rule, we believe that the cost reporting periods used to determine whether a hospital will receive a cap reduction must, at the very least, have been submitted to the Medicare contractor as of March 23, 2010. Furthermore, we do not believe it would be appropriate to include in the determination of which cost reports are used to establish a hospital's reference resident level, those cost reporting periods that occurred at the time the Affordable Care Act was in development. Rather, the cost reporting period used to assess the number of residents a hospital is training for the purpose of determining if it qualifies for an increase to its FTE resident cap should be a cost reporting period that reflects a number of FTE residents that a hospital is accustomed to training, not a number of FTE residents that is based on a hospital's attempt to meet the Demonstrated Likelihood Criteria or the 3-year primary care average requirement under section 1886(h)(8)(B)(ii)(I) of the Act. Therefore, we are clarifying in this final rule that the cost report data to be submitted with a hospital's application for additional slots and the cost reports used to establish a hospital's 3-year primary care average under section 1886(h)(8)(B)(ii)(I) of the Act must also be submitted to the Medicare contractor by March 23, 2010.

13. CMS Evaluation of Applications for Increases in FTE Resident Caps

In the August 3, 2010 proposed rule (75 FR 46400), we proposed to require hospitals to submit, with their applications for increases in their FTE resident caps, a completed copy of the CMS Evaluation Form. The CMS Evaluation Form will ask the hospital to check off which of the "demonstrated likelihood" criteria (described above in section XXI.D.11. of this preamble) the hospital meets. We also proposed to require that the hospital provide the documentation that supports the "demonstrated likelihood" criteria it has checked off on the Evaluation Form.

Assuming that the applicant hospital meets the "demonstrated likelihood" requirement, we proposed that the applicant hospital would indicate on the CMS Evaluation Form the category(ies) for which it believes it will qualify. We would use this indication to prioritize the applications. This prioritization is derived from sections 1886(h)(8)(C), (D), and (E) of the Act, as added by section 5503 of the Affordable Care Act. These sections established considerations in redistribution and a priority order that must be applied in determining the hospitals that will receive increases in their FTE caps. As discussed above, the first consideration in redistribution is that the applicant hospital must demonstrate the likelihood of filling the slots requested within the first three cost reporting periods beginning on or after July 1, 2011. Another consideration is "whether the hospital has an accredited rural training track" (as described in section 1886(h)(4)(H)(iv) of the Act). Accordingly, we proposed that, in distinguishing between hospitals within a priority category, and determining which hospitals will receive FTE cap increases, we would give preference to a hospital that has an accredited rural training track over a hospital that does not have such a program. Under section 1886(h)(4)(H)(iv) of the Act, as implemented in the regulations at § 413.79(k), an urban hospital that operates a rural training track (often known as separately accredited 1–2 tracks in family medicine) wherein residents rotate at the urban hospital for less than one-half of the duration of the program, and to a rural area for the remainder of the program, the urban hospital may include in its FTE count the FTE resident time spent training in the rural track, even if that time would be in excess of the hospital's FTE cap. We note that if an urban hospital is interested in starting a new rural training track, it need not apply for additional slots under section 1886(h)(8)(B)(i) of the Act. Rather, under the existing regulations at § 413.79(k), the urban hospital may receive an increase to its FTE cap to reflect FTE residents training in the rural track. (For more details on rural training tracks, and the direct GME and IME payment rules associated with them, we refer readers to 66 FR 39902, August 1, 2001, and 68 FR 45454, August 1, 2003.) However, because section 1886(h)(8)(C) of the Act states that the Secretary shall take into account "whether the hospital *has* an accredited rural training track" (emphasis added), we proposed that an applying urban hospital that either *has* a separately accredited rural training track, or can document that it *will have* a separately accredited rural training track as of July 1, 2011, may receive preference over a hospital that, all other things being equal, does not and will not have a rural training track by that date. We noted that section 1886(h)(8)(C) of the Act does not specify that a hospital must be applying for additional slots in order to expand its existing rural training track in order to qualify to receive additional slots. Rather, section 1886(h)(8)(C) of the Act merely states that "the Secretary *shall take into account* * * * whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv))" (emphasis added). That is, the fact that an urban hospital *already has* (or, under the proposed rule and this final rule, would have as of July 1, 2011) a separately accredited rural training track is sufficient to give preference in redistribution to such a hospital.

Section 1886(h)(8)(D) of the Act instructs the Secretary to "distribute the

increase to hospitals based on the following factors":

• *Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary) (section 1886(h)(8)(D)(i) of the Act).* In order to determine which States are in the lowest quartile for resident-to-population ratios, in the August 3, 2010 proposed rule (75 FR 46400), we proposed to use three sources of data, and the latest data available for each of those three sources. First, we proposed to determine the number of allopathic residents in each State by using data from the ACGME's Data Resource Book for the Academic Year 2008–2009. As of publication of the proposed rule, this was the most recent data available from the ACGME. However, after publication of the proposed rule, the ACGME released its 2009–2010 Data Resource Book. Therefore, in this final rule, we are using data from the ACGME's Data Resource Book for the Academic Year 2009–2010. In this book, which is available free of charge on the ACGME's Web site, is a table titled "Number of Residents, by State" (*http://www.acgme.org/acWebsite/databook/2009–2010_ACGME_Data_Resource_Book.pdf*). This table lists each State (including Puerto Rico), and includes a column called "Total Residents." We are using the data from this column called "Total Residents" as part of the numerator to determine the resident-to-population ratio in each state. However, because these data only include residents enrolled in ACGME-accredited programs, we also proposed to add to these numbers the number of residents enrolled in AOA-accredited programs. We proposed to access data on the number of osteopathic residents in each State from the AOA, which was provided to CMS upon special request. These data are what is generally published in the AOA's *Journal of the American Osteopathic Association (JAOA).* For the proposed rule, we requested and received data from the AOA for the 2008–2009 academic year as well. Although these data were not to be published in the JAOA for some months, we received permission from the AOA to publish it in the proposed rule. For the final rule, we requested and received data from the AOA for the number of osteopathic residents in each State for the 2009–2010 academic year. These data are also presented in the form of a table listing each State (there are no osteopathic programs in Puerto Rico), and a column for the total number of residents in each State. Therefore, we proposed that the numerator for the ratio for each State would be the sum of the residents from the 2008–2009 ACGME's table for that State, and the residents from the 2008–2009 AOA table for that State. However, for this final rule, the numerator for the ratio for each State is the sum of the residents from the 2009–2010 ACGME's table for that State, and the residents from the 2009–2010 AOA table for that State.

We understand that, although graduates of allopathic medical schools are precluded from training in AOA-accredited programs, there is no similar prohibition on osteopathic residents training in allopathic programs. Because there are osteopathic residents who enroll and participate in allopathic ACGME-accredited programs, we want to ensure that there is no double counting of residents in the numerator. We have learned from the ACGME that their data in the ACGME Data Resource Book include osteopaths, but only those training in ACGME-accredited programs. The AOA data do not include osteopathic residents who are training in ACGME-accredited programs; AOA data only include osteopathic residents enrolled and training in AOA-accredited programs. Therefore, we do not believe there is a concern about double counting with respect to osteopathic residents training in allopathic programs. However, we also are aware that there are some programs that are dually accredited by the ACMGE, and the AOA, and residents completing these programs are able to sit for both the ABMS and the AOA board examination in that specialty. We understand that the ACGME will include a resident in its resident count as long as that resident is training in an ACGME-accredited program, even if that program is dually accredited. The AOA has the same practice of including in its total count of residents those who are in AOA-accredited programs, even if it is a dual eligible program. Therefore, there is some degree of unavoidable double counting of residents in the total count. However, we understand that, as of the publication of the proposed rule, the number of residents in dually-accredited programs was less than 500. We have not been able to receive an updated count of residents in dually accredited programs for this final rule. However, because 500 is only 0.43 percent of the combined ACGME and AOA 2009–2010 resident count of 117,191, we believe the effect of counting these residents by both the ACGME and AOA is negligible and would not harm the integrity of the data.

In the August 3, 2010 proposed rule (75 FR 46401), we proposed to define "resident" in "resident-to-population" ratio as actual individual residents, as opposed to the FTE resident figures that are used for Medicare payment purposes. We believe it is appropriate to define "residents" as actual individual residents in this instance because the intent behind this criterion is to identify those States that have low numbers of physicians-in-training in relation to the general population for which those physicians-in-training are providing health care services. An "FTE" measure, which is the measure used for most Medicare payment purposes, does not accurately reflect the number of individual physicians-in-training providing services in a State.

With regard to State population data to be used in the denominator of each State's resident-to-population ratio, we again proposed to use the latest available data on State populations. We proposed to use data from the Census Bureau that is from the 2000 Census, but that have been updated with the most recent data available as of July 1, 2009. We accessed these data from the following Web site: *http://www.census.gov/popest/states/states.html.* On this Web page, the following data can be found: State population datasets—Population, population change and estimated components of population change: April 1, 2000 to July 1, 2009 (NST–EST2009–alldata). We proposed to use the CSV file at this link. Specifically, we proposed to use the data for State population from the column called POPESTIMATE2009 (Column Q of the CSV spreadsheet). Therefore, we proposed to determine each State's resident-to-population ratio, and specifically those States that fall within the lowest quartile by using the sum of the 2008–2009 ACGME and AOA resident data for each State, as described above, in the numerator for each State, and by using the population data updated as of July 1, 2009, in the denominator for each State from the column called POPESTIMATE2009 in Column Q of the CSV spreadsheet. The following table has been updated for this final rule using 2009–2010 ACGME and AOA resident data. It lists each State, and is sorted by resident-to-population ratio from lowest to highest. The first 13 shaded States are the States in the lowest quartile.

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State Name	Census data as of July 1, 2009	ACGME resident data 2009-2010	AOA resident data 2009-2010	Total resident data	Resident to population ratio
Montana	974,989	20	0	20	0.0021%
Idaho	1,545,801	56	0	56	0.0036%
Alaska	698,473	34	9	43	0.0062%
Wyoming	544,270	40	4	44	0.0081%
South Dakota	812,383	98	0	98	0.0121%
Nevada	2,643,085	253	70	323	0.0122%
North Dakota	646,844	111	0	111	0.0172%
Mississippi	2,951,996	524	6	530	0.0180%
Indiana	6,423,113	1,269	22	1,291	0.0201%
Puerto Rico Commonwealth	3,967,288	811	0	811	0.0204%
Florida	18,537,969	3,446	372	3,818	0.0206%
Georgia	9,829,211	2,064	21	2,085	0.0212%
Arizona	6,595,778	1,378	39	1,417	0.0215%
Oregon	3,825,657	825	11	836	0.0219%
Colorado	5,024,748	1,161	3	1,164	0.0232%
Oklahoma	3,687,050	751	137	888	0.0241%
Utah	2,784,572	685	0	685	0.0246%
Arkansas	2,889,450	714	2	716	0.0248%
South Carolina	4,561,242	1,134	15	1,149	0.0252%
Washington	6,664,195	1,683	5	1,688	0.0253%
Maine	1,318,301	294	42	336	0.0255%
Kansas	2,818,747	718	11	729	0.0259%
Alabama	4,708,708	1,224	0	1,224	0.0260%
Kentucky	4,314,113	1,125	21	1,146	0.0266%

State Name	Census data as of July 1, 2009	ACGME resident data 2009-2010	AOA resident data 2009-2010	Total resident data	Resident to population ratio
New Mexico	2,009,671	547	0	547	0.0272%
California	36,961,664	9,852	222	10,074	0.0273%
New Hampshire	1,324,575	382	0	382	0.0288%
Iowa	3,007,856	840	28	868	0.0289%
Virginia	7,882,590	2,203	77	2,280	0.0289%
Texas	24,782,302	7,117	120	7,237	0.0292%
Wisconsin	5,654,774	1,698	31	1,729	0.0306%
North Carolina	9,380,884	2,910	11	2,921	0.0311%
Hawaii	1,295,178	405	0	405	0.0313%
Tennessee	6,296,254	2,124	13	2,137	0.0339%
New Jersey	8,707,739	2,743	371	3,114	0.0358%
Nebraska	1,796,619	657	0	657	0.0366%
Delaware	885,122	312	18	330	0.0373%
Louisiana	4,492,076	1,757	0	1,757	0.0391%
Minnesota	5,266,214	2,173	10	2,183	0.0415%
West Virginia	1,819,777	652	127	779	0.0428%
Vermont	621,760	268	0	268	0.0431%
Missouri	5,987,580	2,550	121	2,671	0.0446%
Maryland	5,699,478	2,693	0	2,693	0.0472%
Illinois	12,910,409	5,790	322	6,112	0.0473%
Ohio	11,542,645	5,455	631	6,086	0.0527%
Connecticut	3,518,288	2,025	4	2,029	0.0577%
Michigan	9,969,727	4,650	1,381	6,031	0.0605%
Pennsylvania	12,604,767	7,384	894	8,278	0.0657%
Rhode Island	1,053,209	736	23	759	0.0721%
Massachusetts	6,593,587	5,271	15	5,286	0.0802%
New York	19,541,453	15,862	596	16,458	0.0842%
District of Columbia	599,657	1,912	0	1,912	0.3188%

Based on the proposed data, the following States fall within the lowest quartile for resident-to-population ratios: Montana, Idaho, Alaska, Wyoming, Nevada, South Dakota, North Dakota, Mississippi, Florida, Puerto

Rico, Indiana, Arizona, and Georgia. Based on the revised finalized data, although the same States fall within the lowest quartile for resident-to-population ratios, the order changed somewhat as follows: Montana, Idaho, Alaska, Wyoming, South Dakota, Nevada, North Dakota, Mississippi, Indiana, Puerto Rico, Florida, Georgia, and Arizona. Accordingly, we proposed that, consistent with section 1886(h)(8)(D)(i) of the Act, a hospital located in any one of these States that applies for an increase to its FTE cap under section 1886(h)(8)(B) of the Act would receive preference over a hospital that is applying for an increase to its cap that is not located in one of these States.

Comment: One commenter requested that CMS use the most recent resident data from the 2009–2010 academic year in the calculation of the resident-to-population ratios. The commenter noted that since the academic year 2008–2009, there are 80 additional accredited programs and 1,904 additional residents according to the ACGME's web site.

Response: Since the CY 2011 OPPS/ASC proposed rule went on display at the **Federal Register** on July 2, 2010, the ACGME has posted the 2009–2010 Data Resource Book. As we explain in the preamble to this final rule, this book, which is available free of charge on the ACGME's Web site, has a table titled "Number of Residents, by State" (*http://www.acgme.org/acWebsite/databook/2009–2010_ACGME_Data_Resource_Book.pdf*). This table lists each State (including Puerto Rico), and includes a column called "Total Residents." We are using the data from this column called "Total Residents" as part of the numerator to determine the resident-to-population ratio in each state.

• *Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of (1) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to (2) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).*

In order to determine which applying hospitals fall within this priority category, we need to determine the total population living in a HPSA in each State, territory, or District computed "as of the date of enactment," and we need to determine the total population of each State, territory, or District "(as determined by the Secretary based on the most recent available population data published by the Bureau of the Census)." "Territory" is referring to Puerto Rico, which currently has teaching hospitals, and "District of Columbia" refers to Washington, DC. For ease of reference, and consistent with the definition of "State" at section 210 of the Act, we proposed to refer to "State, territory, or District" simply as "State." We have received data on the population of each HPSA from the Health Resources and Services Administration's (HRSA) Geospatial Warehouse. HRSA's Shortage Designation Branch develops shortage designation criteria and uses them to decide whether or not a geographic area, or population group, is a HPSA. HRSA updates HPSA statistics on its Web site on a daily basis, and we have requested and received the data reflective of the "date of enactment"; that is, March 23, 2010. This data, as of this date, remains the same for this final rule. Because HRSA updates the data on its Web site daily, the data as of March 23, 2010 are no longer available on its Web site. (General information on HPSAs and current data can be found on HRSA's Web site at: *http://bhpr.hrsa.gov/shortage/).*

HRSA designates three different kinds of HPSAs: Primary Care HPSAs, Dental HPSAs, and Mental Health HPSAs. While many areas may only be designated as one of these kinds of HPSAs, some areas may be designated as two or three of these kinds of areas. Thus, if we were to add the population in each State that is in a Primary Care HPSA, a Dental HPSA, and a Mental Health HPSA, we would be duplicating the HPSA populations in each State. Therefore, we proposed to use *only* the population in each State that is in a Primary Care HPSA. We believe that it is appropriate to choose to recognize only the Primary Care HPSAs in each State for the purpose of implementing section 5503 because section 5503 is intended to encourage an increase in the number of primary care residents that are currently being trained in hospitals, as is evidenced by the "Requirements" in section 1886(h)(8)(B)(ii) of the Act, as added by section 5503(a)(4), which requires hospitals that receive additional slots under this section to maintain a certain average number of primary care resident positions, and that not less than 75 percent of the redistributed positions must be awarded for slots used in a primary care or a general surgery residency.

With respect to data on each State's total population "as determined by the Secretary based on the most recent available population data published by the Bureau of the Census," we proposed to use the same data that we are using under the first priority category with regard to determining resident-to-population ratios, as explained above. These data, which are the most recent available, were last updated on July 1, 2009. As explained above, we accessed these data from the following Web site: *http://www.census.gov/popest/states/states.html.* On this Web page, the following data can be found: State population datasets—population change and estimated components of population change: April 1, 2000 to July 1, 2009 (NST–EST2009–alldata). We proposed to use the CSV file at this link. Specifically, we proposed to use the data for State population from the column called POPESTIMATE2009 (Column Q of the CSV spreadsheet).

The following table lists each State, its Primary Care HPSA population-to-State population ratio from highest to lowest, and whether that State falls within the top 10 States for such Primary Care HPSA population-to-State population ratios:

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State Name	Census data as of July 1, 2009	Primary Care HPSA	Primary Care HPSA to Population Ratio
Louisiana	4,492,076	3,119,598	69.4467%
Mississippi	2,951,996	1,781,774	60.3583%
Puerto Rico Commonwealth	3,967,288	2,282,408	57.5307%
New Mexico	2,009,671	1,036,774	51.5892%
South Dakota	812,383	351,926	43.3202%
District of Columbia	599,657	257,377	42.9207%
Montana	974,989	384,030	39.3881%
North Dakota	646,844	239,550	37.0337%
Wyoming	544,270	199,656	36.6833%
Alabama	4,708,708	1,725,293	36.6405%
Arizona	6,595,778	1,981,387	30.0402%
Illinois	12,910,409	3,858,062	29.8833%
Missouri	5,987,580	1,780,841	29.7422%
Idaho	1,545,801	453,347	29.3276%
Kentucky	4,314,113	1,155,928	26.7941%
South Carolina	4,561,242	1,159,709	25.4253%
Texas	24,782,302	6,040,714	24.3751%
Delaware	885,122	215,060	24.2972%
New York	19,541,453	4,691,714	24.0090%
Oklahoma	3,687,050	866,358	23.4973%
Georgia	9,829,211	2,276,546	23.1610%
Florida	18,537,969	4,287,169	23.1264%
Tennessee	6,296,254	1,455,365	23.1148%
Alaska	698,473	153,999	22.0480%
Kansas	2,818,747	570,639	20.2444%
Colorado	5,024,748	970,145	19.3073%
Michigan	9,969,727	1,916,653	19.2247%
Nevada	2,643,085	504,174	19.0752%
North Carolina	9,380,884	1,673,482	17.8393%
Iowa	3,007,856	536,519	17.8373%
Wisconsin	5,654,774	998,920	17.6651%
West Virginia	1,819,777	318,133	17.4820%
Arkansas	2,889,450	501,208	17.3461%
Utah	2,784,572	477,193	17.1370%
Washington	6,664,195	1,140,882	17.1196%
California	36,961,664	6,014,851	16.2732%
Virginia	7,882,590	1,222,771	15.5123%

State Name	Census data as of July 1, 2009	Primary Care HPSA	Primary Care HPSA to Population Ratio
Oregon	3,825,657	579,368	15.1443%
Rhode Island	1,053,209	156,064	14.8180%
Connecticut	3,518,288	477,837	13.5815%
Massachusetts	6,593,587	893,375	13.5492%
Indiana	6,423,113	816,234	12.7078%
Maine	1,318,301	156,116	11.8422%
Ohio	11,542,645	1,326,610	11.4931%
Pennsylvania	12,604,767	1,431,314	11.3553%
Minnesota	5,266,214	493,764	9.3761%
Maryland	5,699,478	523,260	9.1808%
Nebraska	1,796,619	146,196	8.1373%
Hawaii	1,295,178	93,107	7.1887%
Vermont	621,760	40,313	6.4837%
New Hampshire	1,324,575	84,038	6.3445%
New Jersey	8,707,739	376,405	4.3226%

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• *Whether the hospital is located in a rural area (as defined in section 1886(d)(2)(D)(ii) of the Act).* Section 1886(d)(2)(D)(ii) of the Act defines a rural area as any area outside a MSA. Under the existing regulations at § 412.62(f)(ii), an "urban area" means: (1) A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA); or (2) the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Under existing § 412.62(f)(iii), a "rural area" means any area outside an urban area. Thus, for purposes of the amendments made by section 5503, in the August 3, 2010 proposed rule (75 FR 46406), we proposed that any hospital located in an area that is not in a MSA is a rural hospital, regardless of any reclassification under § 412.102 or § 412.103. We also pointed out that, since FY 2005, we no longer use the term MSA, but instead we use CBSA, or Core-Based Statistical Area. There are urban CBSAs, and rural CBSAs are areas outside of an urban CBSA. We note that this definition of "rural" is consistent with our policy concerning designation of wage index areas.

We also proposed that, in determining which applicant hospitals receive priority within the priority category of hospitals located in a State in the lowest quartile for resident-to-population ratios that hospitals in a State that is ranked *lower* in the quartile (with number one being the lowest) would receive preference over hospitals in states that are still within the quartile, but ranked higher. For example, all other things being equal, a hospital located in Montana would receive preference over a hospital located in Idaho, while this hospital would receive preference over a hospital located in Alaska, and so on. Similarly, we proposed that, in determining which applicant hospitals receive priority within the priority category of hospitals located in a State that is among the top 10 of these areas in terms of the ratio of Primary Care HPSA population to total population, hospitals in an area that is ranked *higher* in the top 10 (with number 1 being highest and number 10 being lowest) would receive preference over hospitals in an area that are still within the top 10, but ranked lower. For example, all other things being equal, a hospital located in Louisiana would receive preference over a hospital located in Mississippi, while a hospital in Mississippi would receive preference over a hospital located in Puerto Rico, and so on.

Comment: A couple of commenters urged CMS to consider expanding the slot redistribution eligibility to all States, not just those hospitals in States with a low resident-to-population ratio or high proportion of population living in a HPSA or in a rural area. The commenters stated that allowing all states to be eligible will be a faster way to increase the physician supply. The commenters believed that restricting redistribution eligibility would deny training opportunities to qualified residents that may be training at hospitals that are already over their caps. Other commenters also urged CMS to consider a more equitable method to redistribute unused slots to hospitals over their caps.

Response: An action to allow hospitals in all states to be eligible for redistributed slots under section 5503 is not authorized under the Affordable Care Act. As described in the August 3, 2010 proposed rule (75 FR 46390), section 5503 of the Affordable Care Act, which added a new section 1886(h)(8)(E) to the Act, specifically directs the Secretary to distribute 70 percent of the resident slots to hospitals located in States with resident-to-population ratios in the lowest quartile and 30 percent to hospitals located in a State, a territory of the United States, or the District of Columbia that are among the top 10 States, territories, or Districts in terms of the ratio of the total population living in an area designated as a health professional shortage area as of March 23, 2010, to the total population, and to hospitals located in rural areas. Therefore, only those hospitals in States, territories, or

Districts that fall into the aforementioned categories will be considered for redistributions under section 5503.

Comment: One commenter asked CMS to define the cities of Anchorage and Fairbanks, Alaska as rural. The commenter noted that even though the majority of Alaskans live in Anchorage, Fairbanks, or the Mat-Su (57%), most hospitals outside of Anchorage and Fairbanks are not large enough to meet basic requirements for accreditation by the ACGME. Therefore, Anchorage and Fairbanks should be added to the Priority Category and Evaluation Criteria list of rural areas.

Response: We cannot accommodate the commenter's request to classify Anchorage and Fairbanks as rural areas because the reference to rural areas under section 5503 regarding giving preference to hospitals located in rural areas is to subsection (d)(2)(D)(ii) of the Act. Section 1886(d)(2)(D)(ii) of the Act defines a rural area as any area outside a MSA. Under the existing regulations at § 412.62(f)(ii), an "urban area" means, in part, a MSA. Under existing § 412.62(f)(iii), a "rural area" means any area outside an urban area. Thus, for purposes of the amendments made by section 5503, any hospital located in an area that is not in a MSA is a rural hospital, regardless of any reclassification under § 412.102 or § 412.103. We also pointed out in the proposed rule that, since FY 2005, we no longer use the term MSA, but instead we use CBSA, or Core-Based Statistical Area (75 FR 46406). Further, we note that Alaska is already given preference under section 5503 since it is one of the states that is in the lowest quartile for resident-to-population ratios.

As we described above, we proposed that an applicant hospital indicate on the CMS Evaluation Form the category(ies) for which it believes it will qualify, and we will use this indication to prioritize the applications. Each of the categories (described below) was derived from the priorities established by section 1886(h)(8)(D) of the Act, as added by section 5503 of the Affordable Care Act. We proposed to use the following categories to determine the order in which hospitals would be eligible to receive increases in their FTE resident caps:

- *First Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND the hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND the hospital is located in a rural area.
- *Second Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile, and is *either* in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* it is located in a rural area, *or* is an urban hospital and has, or will have as of July 1, 2011 (we note the proposed rule incorrectly stated 2010), a rural training track.
- *Third Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile.
- *Fourth Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, and either the hospital is located in a rural area *or* the hospital is an urban hospital and has, *or* will have as of July 1, 2011 (we note the proposed rule incorrectly stated 2010), a rural training track.
- *Fifth Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* the hospital is located in a rural area.

We believe it is appropriate to establish priority level categories based on the fact that some hospitals that apply for the additional resident slots may fit into more than one of the three statutory priority categories listed in section 1886(h)(8)(D) of the Act. Therefore, we proposed to give consideration first to those hospitals that meet more than one of the statutory priority categories over those hospitals that meet only one of the statutory priorities. We further proposed that a hospital that is in a State whose resident-to-population ratio is within the lowest quartile would receive priority over a hospital that is not located in one of these States. We believe this is consistent with the direction established at section 1886(h)(8)(E)(i) of the Act which specifies that the Secretary shall reserve 70 percent of all positions available for distribution for hospitals in a State whose resident-to-population ratio is within the lowest quartile. Only 30 percent of the positions are to be distributed to hospitals in States whose Primary Care HPSA to population ratio is in the top 10 States, and hospitals located in rural areas. In addition, as discussed above, the first consideration in redistribution under section 1886(h)(8)(C) of the Act is that the applicant hospital must demonstrate the likelihood of filling the slots requested within the first three cost reporting periods beginning on or after July 1, 2011. The second consideration is "whether the hospital has an accredited rural training track" (as described in section 1886(h)(4)(H)(iv) of the Act). Accordingly, we proposed that, in distinguishing between hospitals within priority categories, and in determining which hospitals qualify to receive additional slots, we would give preference to a hospital that has an accredited rural training track as compared to a hospital that does not have such a program.

Because section 1886(h)(8)(E) of the Act specifies that 70 percent of the slots are to be reserved for hospitals that are in a State whose resident-to-population ratio is within the lowest quartile, and 30 percent of the positions are to be reserved for hospitals in States whose Primary Care HPSA to population ratio is in the top 10 States, and hospitals located in rural areas, we proposed that no slots would be given to hospitals that do not fit within either of these categories.

Comment: Some commenters reflected on the method CMS proposed to allocate the slots, in which there would be a single "redistribution pool", out of which 70 percent of the slots will first be awarded to hospitals in Priority Categories 1, 2, and 3, with the remaining 30 percent of the slots being awarded to hospitals in Priority Categories 4 and 5. The commenters further noticed that hospitals that qualify for slots from both the "70-percent pool" and the "30-percent pool" would be awarded slots first, with slots being awarded to these hospitals from only the "70-percent pool." The commenters believed that hospitals in States further down the low resident-to-population list should "not have their chances of being awarded slots unduly diminished by hospitals that qualify under both categories." The commenters believed it is more equitable to allocate slots to hospitals that qualify for both pools by prorating the number of slots awarded between both pools. The commenters included an example where, for a rural hospital in a State on the low resident-to-population list that is awarded 10 slots through the redistribution program, 70 percent, or 7 slots, would come from the "70-percent pool" while 30 percent, or 3 slots would come from the "30-percent pool." The commenters believed that "this result is more easily achieved with two distinct pools of slots, but we defer to CMS as to how to implement the mechanics of prorating."

One commenter suggested that CMS should review and modify its complex prioritization criteria to ensure that 70 percent of the slots go to hospitals in States with low resident-to-population ratios. The commenter noted that under the priority criteria that CMS proposed,

it is possible that a hospital located in a lowest quartile resident-to-population State would not receive any slots. The commenter argued that this was not the intent of Congress and that CMS should develop a process that ensures that all hospitals in the lowest quartile resident-to-population States that apply and meet the demonstrated likelihood criteria receive at least some caps through the redistribution process.

Response: On page 46409 of the August 3, 2010 proposed rule, we discussed the scenario where a hospital could qualify to receive slots from both the "70-percent pool" and the "30-percent pool." We stated that we considered a "possible scenario that could occur with respect to hospitals that fall into the Second Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile, and is *either* in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* it is located in a rural area, *or* is an urban hospital and has or will have as of July 1, 2011, a rural training track. Because a hospital in this second level priority category is located both in a State whose resident-to-population ratio is within the lowest quartile, and is *either* in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* it is located in a rural area, we believe that its request for additional slots must first be fulfilled from the "70-percent pool." However, if there are insufficient slots in the "70-percent pool" to satisfy the requests of all otherwise qualified applicants in the Second Level Priority Category, then, rather than immediately prorating the remaining slots in the "70-percent pool" among the applicable hospitals in the second level priority category, we proposed to draw from the "30-percent pool" to grant the full FTE cap increases (as applicable) to qualifying hospitals in the second level priority category."

The commenters raise a fair point, in that hospitals that qualify to fit into either the "70-percent pool" or the "30-percent pool" (but not both) should not have their chances of receiving their fair share of slots from the respective pools diminished by hospitals that fall into priority categories qualifying for slots from both pools. Section 5503 essentially requires that two distinct pools of slots be created; one for hospitals located in States that are in the lowest quartile for resident-to-population ratios, and one for hospitals located in States that are the top 10 States for Primary Care HPSA to population ratios, or for rural hospitals. We have reconsidered our proposed method described above, which ranks a hospital that is in a State whose resident-to-population ratio is within the lowest quartile, *and* the hospital is located in a State whose Primary Care HPSA to population ratio is in the top 10 States, *and/or* the hospital is rural, above a hospital that is only located in a State whose resident-to-population ratio is within the lowest quartile. We realize that these "doubled" Priority Categories allow for the possibility that a hospital located only in States whose resident-to-population ratios are in the lowest quartile may have its chances of receiving slots diminished by hospitals in States that fall within both priority categories. Therefore, in this final rule, we are reducing the number and revising the Priority Categories as follows:

- *First Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND it is an urban hospital that has, or will have as of July 1, 2011, a rural training track.
- *Second Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile.
- *Third Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND the hospital is an urban hospital that has, or will have as of July 1, 2011, a rural training track.
- *Fourth Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, OR the hospital is located in a rural area.

Priority Level Categories 1 and 2 are for distributing slots in the 70-percent pool, and Priority Level Categories 3 and 4 are for distributing slots in the 30-percent pool. With regard to a hospital that is located in a State that falls into both priority categories, such a hospital's application would be evaluated first based on its Evaluation Criteria within the context of the First and Second Level Priority Categories, and if there are not enough slots left in the 70-percent pool to satisfy the hospital's request, we believe the hospital must be allowed to receive the remainder of its otherwise deserved slots from the 30-percent pool, based on its Evaluation Criteria within the context of the Third and Fourth Level Priority Categories. In distributing the slots from both the 70-percent and the 30-percent pools, we would be sure to do so in a way to ensure that a hospital that falls into both priority categories should not be at a greater disadvantage than a hospital that only is in a State that is in the lowest quartile for resident-to-population ratios.

We are also finalizing our proposal that, in determining which applicant hospitals receive priority within the priority category of hospitals located in a State in the lowest quartile for resident-to-population ratios that hospitals in a State that is ranked *lower* in the quartile (with number one being the lowest) would receive preference over hospitals in States that are still within the quartile, but ranked higher (75 FR 46406). For example, all other things being equal, a hospital located in Montana would receive preference over a hospital located in Idaho, while this hospital would receive preference over a hospital located in Alaska, and so on. Similarly, we are finalizing our proposal that, in determining which applicant hospitals receive priority within the priority category of hospitals located in a State that is among the top 10 of these areas in terms of the ratio of Primary Care HPSA population to total population, hospitals in an area that is ranked *higher* in the top 10 (with number 1 being highest and number 10 being lowest) would receive preference over hospitals in an area that are still within the top 10, but ranked lower. For example, all other things being equal, a hospital located in Louisiana would receive preference over a hospital located in Mississippi, while a hospital in Mississippi would receive preference over a hospital located in Puerto Rico, and so on.

Comment: One commenter stated that the "30-percent pool" must be maintained for distribution of the resident FTE cap slots to rural hospitals as described in section 1886(h)(8)(D)(iii) of the Act. The commenter asserted that "to the extent that this proposal were to diminish the 30-percent pool to the degree that an eligible rural teaching hospital that is not located in a State whose resident-to-population ratio is in the lowest quartile would be contrary to the intent of Congress in establishing the 30-percent pool for hospitals that include rural teaching hospitals." The commenter stated that the Secretary must interpret section 5503 of the Affordable Care Act to reserve some slots from the '30-percent pool' for rural teaching hospitals, that is, hospitals that are rural hospitals but may not also meet either of the other preference criteria at sections 1886(h)(8)(D)(i) and 1886(h)(8)(D)(ii) of the Act.

Response: As we stated in response to a previous comment, we agree that hospitals within States whose resident-to-population ratios are in the lowest quartile should receive 70 percent of the available slots, while hospitals located in States whose Primary Care HPSA to population ratio is in the top 10 States,

or hospitals located in rural areas should receive 30 percent of the available slots. Thus, the commenter need not be concerned that the chances of a rural hospital receiving slots from the '30-percent pool' would be diminished by those slots being diverted to a hospital that is located in a State whose resident-to-population ratio is in the lowest quartile. However, we disagree with the commenter that the Secretary "must interpret section 5503 of the Affordable Care Act to reserve some slots from the "30-percent pool" for rural teaching hospitals" that may not also be located in States with the lowest resident-to-population ratios or States in the top 10 for Primary Care HPSA to population ratios. We note that Congress intentionally placed hospitals located in rural areas and in States in the top 10 for Primary Care HPSA to population ratios *on equal footing,* by specifying clearly that hospitals in both these categories qualify for 30 percent of the redistributed slots. Therefore, all other things being equal, rural hospitals that fit within the final Fourth Level Priority Category, would receive equal preference with hospitals in States whose Primary Care HPSA to population ratio is in the top 10 States. The hospitals, both urban and rural, that fall within this Fourth Level Priority Category would be ranked based on the scores they receive on the applicable Evaluation Criteria, with a higher scoring applicant receiving slots before a lower scoring applicant.

Comment: One commenter stated that section 5503 must be interpreted in a way that gives preference to hospitals located in rural areas that sponsor training programs in the same way as hospitals that have an accredited rural track. This commenter stated that even though it may be less common for a rural hospital to be large and sophisticated enough to support or sponsor teaching programs, these rural hospitals should be eligible for preference under section 1886(h)(8)(C) of the Act. Further, the commenter asserted that a training program located at a teaching hospital in a rural area is even more "rural" than a rural track training program because the overwhelming majority of the training takes place in a rural area, therefore it should meet the second redistribution consideration.

Response: We understand that rural hospitals that engage in GME activities, whether they sponsor those activities directly, or serve as a training site for a program sponsored by another institution, provide valuable health care services to underserved areas. However, we do not believe it is necessary to give additional preference to rural hospitals, above that which is already provided for by section 5503. Section 1886(h)(8)(D)(iii) already provides that hospitals located in rural areas should receive some part of the "30-percent pool." This designation provides rural hospitals with a significant advantage for receiving redistributed slots relative to other hospitals. We also note that we proposed an evaluation criterion, which we are finalizing, that provides a point for rural hospitals that serve as a training site for a rural training track program. Therefore, we do not believe it is necessary to modify the priority categories to give additional preference to rural hospitals that serve as training sites for rural training tracks (which are sponsored by urban hospitals).

After consideration of the public comments we received, in this final rule, we are reducing the number of Priority Categories from five to four, and we are also significantly revising them, as discussed above. We are also finalizing our proposal that, in determining which applicant hospitals receive priority within the priority category of hospitals located in a State in the lowest quartile for resident-to-population ratios that hospitals in a State that is ranked *lower* in the quartile (with number one being the lowest) would receive preference over hospitals in States that are still within the quartile, but ranked higher (75 FR 46406). Similarly, we are finalizing our proposal that, in determining which applicant hospitals receive priority within the priority category of hospitals located in a State that is among the top 10 of these areas in terms of the ratio of Primary Care HPSA population to total population, hospitals in an area that is ranked *higher* in the top 10 (with number 1 being highest and number 10 being lowest) would receive preference over hospitals in an area that are still within the top 10, but ranked lower.

14. CMS Evaluation of Application for Increases in FTE Resident Caps—Evaluation Criteria

We anticipate that there will be a limited number of slots available for distribution from the redistribution pool, while there will be a great demand for those limited slots. Therefore, as we did when implementing section 422 of Public Law 108–173, in the August 3, 2010 proposed rule (75 FR 46406), we proposed to use additional criteria (some of which are the same as those used to implement section 422) for evaluating the applications for increases in hospitals' FTE resident caps within each of the five (we note the proposed rule incorrectly stated seven) level priority categories described above under section 5503. (In this final rule, there are four Level Priority Categories). In addition, in implementing section 5503, we proposed to assign a certain number of points to each evaluation criterion, such that some will be worth more points than others. We noted that the criteria are not mutually exclusive. Hospitals may qualify for a number of different criteria and their "score" is the total point value for all criteria met by the hospital for each program. Because we anticipate that the redistribution pool under section 5503 will be smaller than that under section 422, we believe a more rigorous and competitive ranking system is appropriate under section 5503. Thus, we proposed to assign a different amount of points to each Evaluation Criterion, rather than just assigning one point to each.

Evaluation Criterion One. The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report. (5 Points) We have selected 60 percent utilization because we believe that level would identify hospitals where Medicare beneficiaries will benefit the most from the presence of a residency program, and, although the applicant hospital may be urban or rural, it is consistent with the utilization percentage required for Medicare-dependent, small rural hospitals (MDHs) as specified in § 412.108. In addition, it identifies a type of hospital that warrants atypical treatment by the Medicare program because it is so reliant on Medicare funding.

Evaluation Criterion Two. The hospital will use additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program. (5 Points) Section 5503 places a particular emphasis on increasing the number of residency positions in primary care specialties, as evidenced by the requirements at sections 1886(h)(8)(B)(ii)(I) and (II) of the Act that a hospital that receives slots must maintain at least the same number of primary care residents as it had during the three most recent cost reporting periods prior to enactment, and that not less than 75 percent of additional positions received must be in a primary care or a general surgery residency. Geriatrics is included in the definition of "primary care resident" at section 1886(h)(5)(H) of the Act. We believe that, of all the medical specialties, geriatrics is the one specialty that is

devoted primarily to the care of the elderly, including Medicare beneficiaries. As such, we proposed to give special consideration to geriatric programs to meet the "fill rate" criterion for demonstrating the likelihood of filling FTE resident slots under section 5503. Geriatrics is a subspecialty of family practice or internal medicine. We proposed that, for the purposes of meeting the 85 percent fill rate criterion, we would allow hospitals that are starting a new geriatrics program or expanding an existing geriatric program to use the fill rate associated with the overall specialty program (rather than the fill rate for the geriatric subspecialty) to meet this demonstrated likelihood criterion.

Evaluation Criterion Three. The hospital will use additional slots to establish a new or expand an existing primary care program with a demonstrated focus on training residents to pursue careers in primary care, rather than in nonprimary subspecialties of those primary care programs (for example, the hospital has an internal medicine program with a designated primary care track). (3 Points) As stated previously, section 5503 places a particular emphasis on encouraging the growth in the number of primary care residents, and specifically, physicians who practice in primary care, rather than only completing a primary care residency as a prerequisite for further subspecialty training. Although this proposed Evaluation Criterion applies to any primary care specialty, according to the 2010–2011 ACGME Green Book, 30.1 percent of accredited internal medicine programs offer a primary care track. However, the ACGME does not have separate standards for or does not separately accredit primary care tracks from categorical primary care programs. We understand that, particularly for internal medicine residents, these tracks are a way for graduating medical students who are interested in primary care to declare that interest early on, and in many cases, actually match into an internal medicine program with a primary care track through the National Residency Match Program. These residents may pursue their interest in primary care by choosing to do more electives in ambulatory and community-based settings throughout the 3 years of primary care training than residents with an interest in specialization might do. We believe that encouraging growth of these programs will increase the number of primary care practitioners. Therefore, we proposed to give special consideration to hospitals that are applying for additional slots to start or expand a program(s) that particularly focuses on residents who wish to pursue careers in primary care, and we would prioritize among hospitals that are applying for slots in a primary care program(s) accordingly. One example of a hospital that demonstrates a focus on training residents to pursue careers in primary care is a hospital that has a primary care track in internal medicine. We proposed that one way hospitals may qualify for a point under this evaluation criterion is by documenting that they are advertising that they have an internal medicine program with a primary care track in the March 2011 National Residency Match Program.

Evaluation Criterion Four. The hospital will use all the additional slots to establish a new or expand an existing primary care residency program or general surgery program. (5 Points) "Primary care resident" is defined at section 1886(h)(5)(H) of the Act as a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. Section 1886(h)(8)(B)(ii)(II) of the Act states that not less than 75 percent of additional positions received must be in a primary care or a general surgery residency. Therefore, we proposed to award 5 points to a hospital that goes beyond this minimum requirement, and documents that it will use *all* of the slots received for either primary care or general surgery programs.

Evaluation Criterion Five. The hospital is located in a Primary Care HPSA. (2 Points) We believe this evaluation criterion is consistent with the goal of reducing the shortage of primary care physicians, and increasing access to care in underserved areas.

Evaluation Criterion Six. The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is or will be on or after July 1, 2011, a training site for a rural track residency program (as specified under § 413.79(k)), but is unable to count all of the FTE residents training in the rural track because the rural hospital's FTE cap is lower than its unweighted count of allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011. (1 Point) We understand that there are some rural hospitals that serve as training sites for an urban hospital's rural training track. The residents in the rural track are counted in the urban hospital's FTE count, but because the rural training tracks are not necessarily considered "new" medical residency programs according to the regulations at § 413.79(l), the rural hospital cannot receive an increase in its FTE caps under § 413.79(e)(3) and, therefore, cannot receive direct GME and IME payments for training all or some of those residents. The rural hospital may be training residents in excess of its FTE resident cap prior to July 1, 2011 and, therefore, cannot receive IME or direct GME payment for some or all of the FTEs in the rural training track, or it wishes to expand its rural training track above its FTE resident cap on or after July 1, 2011. We proposed this evaluation criterion as a remedy to these scenarios to allow the rural hospital the possibility of receiving payment for FTEs in its rural training track.

We proposed to use these criteria to evaluate the applications by hospitals for increases in their FTE resident caps that fall within each of the five (we note that the proposed rule incorrectly stated seven) level priority categories. (In this final rule, there are four Level Priority Categories). We proposed to place each application in the appropriate priority level category based on a review of the information a hospital checks off on the proposed CMS Evaluation Form for each allopathic and osteopathic specialty program requested by the applicant hospital, and the corresponding requested FTE cap increase. We proposed to place all of these evaluation criteria on the CMS Evaluation Form and to ask the hospital to check off which criteria on the form apply for each specialty program for which an FTE cap increase is requested. Based on the evaluation criteria checked off on the form, we proposed to score each CMS Evaluation Form. The higher-scoring CMS Evaluation Form(s) for each applicant hospital within each level priority category would be awarded the FTE resident cap increases first. It is possible that a hospital may qualify for multiple points for the same program. For example, if a hospital would be applying for slots to start a primary care track within an internal medicine program, and also would be using *all* of the slots it receives in that internal medicine program, the hospital may receive points both for Evaluation Criterion Three and Evaluation Criterion Four. Similarly, if a hospital would be applying for slots to start or expand a geriatrics program, and the additional slots would all be used for the geriatrics program, then the hospital may receive points for both Evaluation Criterion Two and Evaluation Criterion Four. Further, as specified by section 1886(h)(8)(E) of the Act, 70 percent of all positions are reserved to be

distributed to qualifying hospitals that are in States with resident-to-population ratios in the lowest quartile, and 30 percent of the positions are reserved to go to hospitals that are located in States with HPSA population to State population ratios within the top 10 and to rural hospitals. As we described above, we proposed to award the cap increases in the order of the five (we note the proposed rule incorrectly stated seven) specified level priority categories because, as a general rule, we believe hospitals that meet more than one of the statutory priorities should be awarded the increases in their FTE resident caps first before other hospitals. (In this final rule, there are four Level Priority Categories). We also believe that hospitals that meet a higher statutory priority category should receive first consideration over hospitals that meet lower statutory priorities. Furthermore, in the case where, for example, Hospital A's application for a program falls within the Level Priority Category One, but scores no points on the evaluation criteria on the CMS Evaluation Form for that program, and Hospital B's application for a program falls within the Level Priority Category Two, and scored 5 points on the evaluation criteria on the CMS Evaluation Form for the program, Hospital A would receive the section 5503 cap increase *before* Hospital B, because Hospital A qualified to be in the higher level priority category.

Thus, first level priority category hospitals that score highest on the evaluation criteria on the CMS Evaluation Form for a particular specialty program would receive the increases in their FTE resident caps first. For example, if Hospital D is a hospital that is located in Idaho, thereby falling within the second level priority category, and Hospital D checks off on the CMS Evaluation Form that it has a Medicare utilization of 60 percent (5 points), is using all the slots to expand a primary care residency program (5 points), and is located in a Primary Care HPSA (2 points), Hospital D would receive a score of 12 points on the completed CMS Evaluation Form. We proposed that we would first award FTE cap increases to hospitals whose CMS Evaluation Forms for a particular program receive the most points (if there are any), and then to those with successively fewer points within the level priority category. Hospital D would receive the increase in its FTE resident cap(s) requested on its application only after all the hospitals in the first level priority category whose applications receive 13 or more points are awarded their requests first. We proposed to proceed through each level priority category accordingly, and only move on to distribute slots to hospitals in the next priority level category once all the qualifying applicants in the previous priority level category have received slots. Once we have distributed 70 percent of the slots to hospitals within States with resident-to-population ratios in the lowest quartile in accordance with the First and Second Level Priority Categories (or awarded increases to all qualified applicant hospitals located in States with resident-to-population ratios in the lowest quartile), we proposed to then distribute the remaining slots to hospitals in the Third and Fourth Level Priority Categories. Because of this requirement that 70 percent of the slots be reserved for distribution to hospitals within States with resident-to-population ratios in the lowest quartile, it is possible that after first distributing slots to hospitals with the highest scores on their CMS Evaluation Form, if there are requests for slots by those hospitals which in the aggregate exceed the 70 percent of slots available, there may be some remaining qualifying hospitals within the same priority level category that receive the same score on the CMS Evaluation Form. Thus, we would have no way of distinguishing among these hospitals of equal rank. If this situation occurs, we proposed to prorate the remaining amount of slots in the "70-percent pool", and distribute an equal share of slots to these hospitals of equal rank. If a similar situation occurs within the "30-percent pool", we also proposed to prorate the remaining amount of slots in the "30-percent pool", and distribute an equal share of slots to hospitals of equal rank.

For example, assume all applicant hospitals in the First Level Priority Category receive the requested increases in their FTE resident caps, and that we have awarded cap increases for all the Second Level Priority Category hospitals that scored 5 or above on their CMS Evaluation Forms for each residency program. We next evaluate hospital applications and accompanying CMS Evaluation Forms in the Second Level Priority Category (The hospital is in a State whose resident-to-population ratio is within the lowest quartile) with fewer than 5 points and we find that there is only a sufficient number of resident slots remaining in the estimated "70-percent pool" to grant half of the requests for slots from hospitals that scored 4 points. We proposed to prorate all of the remaining FTEs among the 4-point CMS Evaluation Forms and accompanying applications in the Second Level Priority Category. Thus, after awarding slots to hospitals in the Second Level Priority Category with at least 5 points, and to hospitals in the First Level Priority Category, if we could have awarded a total of 200 FTE slots for direct GME and 185 FTE slots for IME to only 50 percent of the 4-point CMS Evaluation Forms in the Second Level Priority Category (at the point that the estimated "70-percent pool" of FTE slots is spent), we proposed to divide all of the 200 FTE slots remaining in the 70-percent pool for direct GME and 185 FTE slots for IME among *all* of the 4-point CMS Evaluation Forms and accompanying applications in that Second Level Priority Category, no matter what level of FTE resident cap increase was requested on the individual hospital's application, but not to exceed the number of slots a hospital requested for IME and direct GME respectively.

We also considered another possible scenario that could occur with respect to hospitals that fall into the proposed Second Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile, and is either in a State whose Primary Care HPSA to population ratio is in the top 10 States, or it is located in a rural area, or is an urban hospital and has or will have as of July 1, 2010, a rural training track. Because a hospital in the proposed Second Level Priority Category is located both in a State whose resident-to-population ratio is within the lowest quartile, and is either in a State whose Primary Care HPSA to population ratio is in the top 10 States, or it is located in a rural area, we believed that its request for additional slots must first be fulfilled from the "70-percent pool." However, if there are insufficient slots in the "70-percent pool" to satisfy the requests of all otherwise qualified applicants in the Second Level Priority Category, then, rather than immediately prorating the remaining slots in the "70-percent pool" among the applicable hospitals in the proposed Second Level Priority Category, we proposed to draw from the "30-percent pool" to grant the full FTE cap increases (as applicable) to qualifying hospitals in the proposed Second Level Priority Category. (We note that the proposed Second Level Priority Category and its attending policy were changed in this final rule).

Alternatively, although unlikely, we recognize that the reverse situation may occur, where there may not be a sufficient number of qualified applicants or requests for FTEs in order to distribute at least 70 percent of the

slots to hospitals located in the 13 States whose resident-to-population ratios are in the lowest quartile (the First and Second Level Priority Categories). Should this occur, we proposed to begin evaluating applications from the next category of qualifying hospitals (that is, those located in States that are among the top 10 States for Primary Care HPSA to population ratios, and rural hospitals—the Third and Fourth Level Priority Categories), and potentially distribute more than 30 percent of the slots to hospitals in those latter categories.

We recognize the complexity of the proposed evaluation process for the award of increases in hospital's FTE resident caps under section 1886(h)(8)(B) of the Act. Therefore, we included the following examples depicting the proposed procedures:

Example 1

Hospital H is an urban hospital located in a State that is in the lowest quartile for resident-to-population ratios. Hospital H can demonstrate the likelihood that it will fill the requested five FTEs resident slots for direct GME and IME for expanding a geriatric program because it is currently training a number of FTE residents that exceeds both of its FTE caps, and has attached to its application for the increase a copy of Hospital H's past three Medicare cost reports (as filed or audited, whichever is most recent and available), which documents on Worksheet E, Part A, Worksheet E–3, Part IV, and Worksheet E–3, Part VI that, according to the resident counts and the FTE resident caps, Hospital H is training residents in excess of its caps. Hospital H is also located in a Primary Care HPSA (but is not located in a State that is among the top 10 States in terms of its Primary Care HPSA population to State population ratio).

We would evaluate Hospital H's application as follows: Hospital H is in the Second Level Priority Category (The hospital is in a State whose resident-to-population ratio is within the lowest quartile), and receives a score of 12 (expanding a geriatrics program-Evaluation Criterion Two—5 points, using all slots for a primary care residency program-Evaluation Criterion Four—5 points, and is located in a Primary Care HPSA–Evaluation Criterion Five—2 points).

Example 2

Hospital J is a rural hospital located in Montana. Hospital J is a rotation site for an urban hospital's family practice rural training track program, but is unable to count all of the FTE residents training in the rural track because Hospital J's FTE cap is lower than its unweighted count of allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011. Hospital J wishes to expand the number of FTE residents training in the family practice rural training track. Hospital J also wishes to serve as a training site for one pediatrics resident in a pediatrics program that already exists at the urban hospital (that is, it is not a new pediatrics program).

Hospital J would need to submit two CMS Evaluation Forms; one for family practice and another for pediatrics, and we would evaluate each accordingly. Both requests would put the hospital in the Second Level Priority Category (The hospital is in a State whose resident-to-population ratio is within the lowest quartile), and it can demonstrate the likelihood of filling the slots (because it is already over its FTE caps based on the family medicine residents it is training in the rural training track, and together with the urban hospital, it has requested from the ACGME accreditation to expand the number of family practice residents training in the rural training track and to receive a pediatrics resident). For the family practice request, Hospital J would receive 5 points under Evaluation Criterion Four because *all* the slots it is requesting (that is, family practice *and* pediatrics) are for primary care programs, and it would receive 1 point under Evaluation Criterion Six because it is requesting the family practice slots for its rural training track, for a total of 6 points for the family practice request. For the pediatrics request, Hospital J would be placed in the Second Level Priority Category, and receives 5 points under Evaluation Criterion Four because *all* the slots it is requesting (that is, family practice and pediatrics) are for primary care programs.

Comment: Some commenters objected to the 5 points that CMS proposed to award to a hospital under Evaluation Criterion One: *The hospital that is requesting the increase in its FTE residents cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent cost reporting periods for which there is a settled cost report (5 points*). The commenters urged CMS to reduce the number of points awarded from 5 to 1, asserting that "CMS pays hospitals their proportionate Medicare share for their resident training costs, regardless of what that Medicare share may be, and hospitals with smaller Medicare utilization numbers have no less need for Medicare support for their residency programs." However, another commenter stated that they are "wholly supportive" of Evaluation Criterion One because it "gives priority recognition to hospitals reliant on Medicare funding, and where beneficiaries will benefit most from an increase in residency slots." Commenters also asked that CMS consider determining the 60 percent share by calculating Medicare inpatients as a share of Medicare and privately insured patients, or Medicare patients plus Medicaid patients plus uninsured patients as a share of total patients. The commenter believed that teaching hospitals that treat a significant number of Medicaid and uninsured patients should not be put at a disadvantage under this criterion. The commenter also requested that CMS accept *submitted* cost reports (and not just settled cost reports) for this evaluation criterion, due to the time lag in settling cost reports. Lastly, commenters asked that CMS clarify that Medicare Advantage patients may be counted toward a hospital's Medicare inpatient utilization for purposes of this evaluation criterion.

Response: We proposed and finalized a similar Evaluation Criterion under section 422 of the MMA and received similar comments (we refer readers to 69 FR 49150, August 11, 2004). We continue to believe, as we did then, that an Evaluation Criterion geared to hospitals, urban or rural, that treat a disproportionately high percentage of Medicare patients is appropriate because Medicare beneficiaries at these hospitals will benefit greatly from the presence of a residency program, and further, these hospitals are typically reliant on Medicare funding. Therefore, we are not reducing the number of points allotted to this Criterion from 5 to 1. We also proposed that the determination of whether a hospital qualifies for this criterion should be made based on at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report because this condition is modeled after the Medicare Dependent Hospital regulations at § 412.108. We continue to believe that the 60 percent threshold is appropriate for purposes of establishing priorities under section 5503, based on most recently audited and settled cost reports. Therefore, we are not adopting the commenters' suggestion to lower the percentage threshold, or that we accept as-submitted cost reports. Further, we do not believe it is appropriate to include non-Medicare, Medicaid, or private payer utilization for purposes of Evaluation Criterion One. This would

not be consistent with longstanding regulations regarding the computation of Medicare utilization, be it for Medicare GME purposes or otherwise. Finally, we are clarifying that in determining whether a hospital qualifies under this Evaluation Criterion One, the hospital's Medicare Advantage patient load may be incorporated into the Part A patient load (in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report) to determine whether the hospital has a Medicare inpatient utilization of over 60 percent. The hospital may document its Medicare Advantage (MA) patient days for the respective cost reports in the areas of the hospital subject to the IPPS, the IPF PPS (for psychiatric distinct part units), and the IRF PPS (for rehabilitation distinct part units) using data from the Provider Statistical & Reimbursement (PS&R) Report, report type 118.

Comment: One commenter stated that they "appreciate[s] CMS' careful construction of evaluation criteria for determining increases in FTE resident caps," but proposed that CMS consider including language referencing the Health Resources and Services Administration's (HRSA) Teaching Health Center (THC) program and the recently-awarded Primary Care Residency Expansion (PCRE) grants in the discussion of Evaluation Criteria Three and Four, which both relate to new or expanded primary care residency programs. The commenter believed that the inclusion of THC residencies in the CMS criteria and the possibility of receiving additional cap slots would encourage hospitals to participate in the formation and operation of these programs. The commenter also suggested that hospitals associated with HRSA's PCRE grants, which award 5-year grants to cover stipends of primary care residency programs to encourage hospitals to increase their number of primary care trainees, should be eligible for increases in their FTE resident caps. The commenter noted that these hospitals are not allowed to claim Medicare GME payments for the new residents until after the grant ends.

Response: While the THC program, the PCRE grants, and section 5503 are all intended to try to increase the number of primary care physicians training in community non-hospital settings, we are unsure whether it is necessary to link all three provisions for purposes of awarding slots under section 5503. Presumably under the THC program, the residents will be spending the majority of their training time in the THC, which is a non-hospital site and, therefore, is not subject to FTE resident cap rules. We further presume that the THC would be incurring the costs of the residents' salaries and fringe benefits for the time spent training at the THC. We are not convinced that a hospital should receive points merely because it will be associated with a program occurring at a THC. With regard to the PCRE grants, if, as the commenter stated, a hospital receiving that grant cannot claim Medicare GME payments anyway until the grant ends, we do not see how such a hospital would benefit from the receipt of additional slots under section 5503, which are funded by Medicare, unless those slots would be used for some other primary care program not associated with the grants. After considering the public comment, we believe it would be overly complicated, and possibly not even necessary, to incorporate into the Evaluation Criteria a preference for a hospital that is associated with the THC program and/or the PCRE grants. We believe that if the goal is to increase the number of primary care residents, the proposed Evaluation Criteria already clearly give preference to hospitals requesting slots for use in primary care programs.

Comment: One commenter stated that Evaluation Criterion Two should be expanded. Although supportive of incentives for geriatrics training, this commenter stated that geriatrics is only a limited subspecialty of primary care similar to gastroenterology, sports medicine, or adolescent medicine.

Response: We believe it is appropriate to have an Evaluation Criterion that focuses exclusively on geriatrics because not only is geriatrics a specialty that directly affects Medicare beneficiaries, but, unlike gastroenterology, sports medicine, or other subspecialties of primary care programs, it is specifically defined in the statute as being "primary care" (we refer readers to the definition of "primary care resident" at section 1886(h)(5)(H) of the Act). Therefore, we are not adopting the commenter's suggestion.

Comment: A commenter stated that the intent behind Evaluation Criterion Three is excellent, "but it has no teeth." The commenter suggested that for programs such as internal medicine, with a primary care track, the more important criterion is what the output of primary care physicians has been in recent years, and whether the new slots would, in fact, be used for the primary care track positions. The commenter recommended that CMS require applicants to include a review of recent graduates of the program, including information regarding what type of practice the graduates are involved in 2 years following graduation from this program. Further, the commenter suggested that if CMS sets a threshold of 50 percent for the percentage of graduates practicing only primary care within 2 years after graduation to attain these points, it would capture programs that are actually producing more primary care physicians. The commenter asserted that the same logic could be applied to Evaluation Criterion Four.

Also related to Evaluation Criterion Three, this commenter requested that CMS clarify whether family medicine would be included in this criterion. Lastly, the commenter recommended that if a program wishes to expand its number of family medicine residents, or establish a new program in family medicine, it should get at least an additional point for Evaluation Criteria Three and Four, because "unlike other primary care programs, the vast majority of family medicine graduates will be serving as primary care physicians upon graduation into practice."

Response: We believe that implicit in Evaluation Criterion Three, which is targeted to primary care programs with a "*demonstrated* focus" on residents who pursue careers in primary care is the assumption that applicant hospitals that wish to receive the 3 points under Evaluation Criterion Three must "demonstrate" that residents graduating from their programs actually do practice in primary care, and do not enroll in nonprimary care subspecialty programs or work as something other than a primary care practitioner. The commenter's recommendation that applicants include a review of recent graduates of the program, including information regarding what type of practice the graduates are involved in 2 years following graduation from this program, is a reasonable method for documenting that focus. For example, hospitals applying for consideration under Evaluation Criterion Three could provide documentation regarding residents who completed the primary care program in question in June 2008, and in what capacity those graduates have been practicing, at least through June 2010. The commenter suggested that CMS set a threshold of 50 percent for the percentage of graduates practicing only primary care within 2 years after graduation to "demonstrate" that their program focuses on residents who wish to pursue careers in primary care. We believe that a threshold of *greater than* 50 percent would be acceptable as a basis to demonstrate that

a program produces physicians who pursue careers in primary care. We are choosing more than 50 percent as the threshold because this is consistent with the Evaluation Criterion added in this final rule for hospitals that request additional slots for an existing program(s) for which the hospital can demonstrate that more than 50 percent of residents completing the program(s) go on to practice in a rural area or a Primary Care HPSA.

While Evaluation Criterion Three does focus on outcomes, which as explained in the previous paragraph, applicant hospitals must demonstrate, we do not think it is necessary that Evaluation Criterion Four also focus on outcomes. Considering that section 1886(h)(8)(B)(ii) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, already establishes its own rules for a 5 year probationary period and establishes a primary care threshold for which a hospital that receives slots cannot fall below, we are not adopting the commenter's recommendation that applicants applying for the 5 points under Evaluation Criterion Four also be required to demonstrate the practice outcomes of its graduates.

In response to the commenter's request, we are clarifying that slots requested for use in a family practice program may fall under Evaluation Criterion Three. As we stated in the proposed rule (75 FR 46407), Evaluation Criterion Three is for primary care programs with a demonstrated focus on training residents to pursue careers in primary care, and family medicine is a primary care program. Internal medicine programs with primary care tracks are just one type of several primary care programs that may qualify for 3 points under Evaluation Criterion Three. Further, as we explained on page 46408 of the proposed rule, a hospital may qualify for multiple points for the same program. For example, it is possible for a primary care program to qualify for 3 points under Evaluation Criterion Three and for 5 points under Evaluation Criterion Four. However, contrary to the commenter's last request, we do not think it is necessary to provide an extra point for family medicine programs that qualify under Evaluation Criteria Three or Four, simply because most graduates of family medicine programs practice as primary care physicians. While that is a laudable goal, we believe that each primary care specialty, family practice or otherwise, from which the graduates dedicate themselves to pursue careers in primary care, deserves an equal amount of points.

Comment: One commenter expressed that the presence of a primary care track for an internal medicine residency does not justify any additional weighting of an application from such a residency over another internal medicine residency without such a track. The commenter explained that many internal medicine residency programs are entirely focused on primary care training and subsequently do not need a separately labeled primary care track while other programs do not want the burden of managing two tracks for the training program and have dissolved the administrative listing of a track but not the educational experiences in the program. The commenter requested that if CMS does not eliminate this preference, then it should allow non-track programs the opportunity to demonstrate equivalency.

Response: We believe the commenter has misunderstood the proposed Evaluation Criterion Three, which already *allows* "non-track" programs to demonstrate equivalency. The proposed Evaluation Criterion Three states, "*The hospital will use additional slots to establish a new or expand an existing primary care program with a demonstrated focus on training residents to pursue careers in primary care, rather than in nonprimary subspecialties of those primary care programs (for example, the hospital has an internal medicine program with a designated primary care track).*" Therefore, the proposed Evaluation Criterion Three allows any primary care program to demonstrate a focus on training residents to pursue careers in primary care, rather than in nonprimary care subspecialties of primary care programs. We also stated on page 46407 of the August 3, 2010 proposed rule that this Evaluation Criterion applies to any primary care specialty. Internal medicine programs with primary care tracks were provided as just one example of primary care programs that may be able to demonstrate a focus on training residents to pursue careers in primary care. Thus, as the commenter requested, we already intended to allow "non-track" internal medicine or other primary care programs to demonstrate equivalency.

Comment: One commenter suggested that the proposed evaluation criteria together with the proposed prioritization framework could result in few or no residency slots being awarded to general surgery residencies. Though the commenter noted that they do not believe CMS intended to exclude general surgery residency programs from the redistribution, the commenter expressed concern that there is a formulaic bias in the proposed rule as a whole that could produce this result. The commenter urged CMS to re-examine these criteria and the proposed priority categorization schema or otherwise find a means to ensure that general surgery residency programs seeking additional slots will have a reasonable opportunity of securing them. Moreover, the commenter noted that general surgery programs would be able to demonstrate the likelihood of filling additional positions because these programs have a track record of attracting candidates and filling positions.

Response: We are unsure why the commenter believes that few or no slots will be awarded to general surgery residencies. Section 1886(h)(8)(B)(ii)(II) of the Act specifically requires that a hospital must ensure that at least 75 percent of the slots it receives are used to train primary care or general surgery residents. Some hospitals may choose to use their slots for a combination of primary care or general surgery residents, while others may choose to use 75 percent of their slots for only one or the other. Further, we have included Evaluation Criterion Four, which awards 5 points to applicants that will use all the additional slots for a primary care or a general surgery program(s).

Comment: One commenter urged CMS to assign an increased point value for Evaluation Criterion Five. The commenter cited the 2009 National Healthcare Disparities Report, issued by the Agency for Healthcare Research and Quality that showed a lack of significant progress in addressing health care disparities. This commenter believes that primary care plays a large role in working to eliminate health care disparities and thus more emphasis should be placed on primary care HPSAs.

Response: We agree that it is important to address the health care disparities in Primary Care HPSAs and underserved areas. In response to an earlier comment, we stated that we are adding an additional Evaluation Criterion for hospitals that request additional slots for an existing program(s) for which the hospital can demonstrate that more than 50 percent of residents completing the program(s) go on to practice in a rural area or a Primary Care HPSA. Therefore, rather than increase the point value under existing Evaluation Criterion Five, we are adding a new Evaluation Criterion to address the health care disparities in underserved areas.

Comment: One commenter observed that a hospital could potentially "work the system" of points because there is no requirement on how many additional slots would be necessary in order to be

considered an expanded program under Evaluation Criterion Two for geriatrics. The commenter argued that the same logic also applies to Evaluation Criterion Three. Therefore, the commenter suggested that a varying amount of points be assigned based on the number of geriatrics or primary care residents that are to be added under Evaluation Criteria Two and Three, respectively.

Response: The commenter is correct that a hospital may request as little as one FTE slot for use in a geriatrics program (using Evaluation Criterion Two as an example), and simply because that slot is for geriatrics, the hospital will receive 5 points for that request. However, we note that the points are allocated by program and, therefore, an applicant cannot use the points awarded in response to a request for slots for use in a geriatrics program to gain an advantage in its request for slots for use in another type of program. The points awarded for geriatrics would only benefit the hospital in its request for slots to be used in a geriatrics program. Similarly, the points awarded under Evaluation Criterion Three would only benefit the hospital for that request.

Comment: One commenter stated that the proposed system of selecting States for priority status in the redistribution is flawed and that it would ultimately only benefit the "ultra large training institutions." The commenter noted that these institutions only average 9 percent of their training in primary care. Moreover, the commenter stated that "the large to ultra large hospitals received 82 percent of all FTEs redistributed to these areas in the 2003 redistribution." The commenter further stated that the proposed requirement that 75 percent of the slots are to be used for primary care will also not be met. The commenter asserted that large institutions that train only 9 percent of their residents in primary care "will gladly keep these slots in primary care for 5 years and then they will convert them to sub-specialty programs." Therefore, a redistribution of FTEs to these hospitals would not meet the goal of primary care growth. This commenter suggested that rewarding hospitals that already have a track record of supporting primary care would be a better mechanism for redistribution. Specifically, the commenter proposed that a descending list of ratios of primary care residents to other residents at each hospital would be a simple way to measure a hospital's level of support for primary care residents. The commenter suggested that any available slots should be awarded across the country to hospitals based upon this descending percentage list, allowing every teaching hospital the chance to receive new FTE slots based upon their past performance.

Response: As the commenter is aware, the method for selecting States for priority status to receive slots is prescribed under section 5503 and, therefore, the Secretary has little, if any, discretion to alter it. Although we certainly cannot predict with great accuracy which hospitals will apply for and receive slots under section 5503, we disagree with the commenter that the redistribution criteria will benefit the "ultra large teaching institutions" who, according to the commenter, only train about 9 percent of their residents in primary care. We note that under section 1886(h)(8)(D) of the Act, which prescribes the priority that should be given to certain areas (that is, to hospitals located in States that are in the lowest quartile for resident-to-population ratios, to hospitals located in a State that is among the top 10 States for primary care HPSA to population ratios, or hospitals located in rural areas), these States generally have teaching hospitals that are relatively small and moderate in size, and the preference categories do not include States located in the Northeast, which contains the country's highest concentration of residents and large teaching institutions. However, we do agree with the commenter that hospitals that already have a track record of training residents in primary care should be recognized in the redistribution process. We believe that Evaluation Criterion Three serves this purpose, under which hospitals that are requesting slots for a primary care program with a demonstrated focus on training residents to pursue careers in primary care may receive 3 points on their application requesting additional slots.

Comment: One commenter disagreed with the First Level Priority Category requirement that a hospital must be located in a rural area and stated that many rural hospitals do not have the infrastructure to support GME. This commenter suggested that placement of a hospital's graduates in rural areas or HPSAs or in practices that serve an underserved population, such as Federally Qualified Health Centers, Medically Underserved Areas, or Medically Underserved Populations, would be a more logical requirement. This same commenter also requested that "integrated rural training tracks" be considered for Second Level Priority Category. The commenter noted that this term is included in the statute, but has not yet been defined by CMS. The commenter proposed that a program with a minimum of 3 months required rural training (integrated in any time frame in its curriculum) should be eligible to be considered an accredited training program with an integrated track. The commenter also reiterated that CMS should consider the resident placement outcomes of a hospital more than its physical location.

Response: Section 1886(h)(8)(D)(iii) of the Act specifically states that hospitals located in rural areas receive preference for receiving redistributed slots. Therefore, the Secretary does not have the flexibility to divert those slots to hospitals in urban areas or to hospitals that generally serve "underserved" populations that are not located in a State that falls within the top 10 States for Primary Care HPSA to population ratios. Similarly, the statute specifically states that the Secretary shall take into account hospitals that have an "accredited rural training track," not an "integrated rural training track." Furthermore, as we know from the ACGME, there is no defined category of programs called "integrated rural training tracks" and therefore, we cannot give special recognition under the priority categories to hospitals that operate integrated rural training tracks. However, the commenter raises a legitimate policy consideration with regard to the suggestion that CMS should consider resident placement outcomes more so than the hospital's physical location. Although we cannot create new priority categories, we do have the flexibility to create additional Evaluation Criteria for use in distinguishing among applicant hospitals within each priority category. Therefore, in this final rule, we are adding an additional Evaluation Criterion for hospitals that request additional slots for an existing program(s) for which the hospital can demonstrate that more than 50 percent of residents completing the program(s) go on to practice in a rural area or a Primary Care HPSA.

Comment: One commenter stated that in addition to the proposed categories of hospitals that would be awarded points in applying for additional slots, CMS should create several additional categories for which hospitals could receive points in the application process as well. The commenter suggested the following additional Evaluation Criteria: (1) Hospitals that exceed their caps—hospitals that have undertaken to train physicians without any financial support from Medicare because it is their "mission obligation" to do so deserve recognition, and CMS should

consider "giving even more weight to those hospitals that are significantly over their resident caps compared to other hospitals that are over their caps"; (2) Hospitals that are in the process of building programs and would lose slots during the build-up period—This would protect hospitals that have made the investment of time and resources to receive accreditation for a new program, and appear to have unused slots but actually are in the middle of a several year build-up process; (3) Hospitals that lose slots for "purely technical reasons"—One example would be hospitals whose "highest" resident count during the three most recent cost reports ending on or before March 23, 2010, did not occur in the year with the smallest difference between its cap and its count and, therefore, would lose slots under CMS' proposed interpretation of the statute.

Response: As we have stated in response to previous comments, and discuss in greater detail below, we believe the intent of section 5503 is to increase the number of primary care or general surgery physicians and, therefore, the provision provides funding for new or expanded programs in primary care and general surgery, rather than funding for existing positions. Therefore, we are not adopting the commenter's request to add an Evaluation Criterion for hospitals that are exceeding their FTE resident caps. With regard to the second request, since we are exempting new teaching hospitals that do not have their FTE resident caps established in all three of their reference cost reports from cap reductions, the commenter's request to add an Evaluation Criterion to protect these new teaching hospitals is no longer necessary. Finally, in response to the commenter's third request, we decline to accept the recommendation to add Evaluation Criteria to protect hospitals that lose slots for "purely technical" reasons, as this is a difficult category to define and limit.

Comment: One commenter noted that CMS has little discretion in developing regulations given how prescriptive the statutory language is, but that does not change the reality of the need for more residency trained and board-certified emergency physicians in rural America. The commenter asked that the redistribution criteria be modified to allow new or expanding emergency medicine programs in the designated shortage States to qualify. Moreover, this same commenter noted that current ACGME residency accreditation requirements cannot be met by a total rural residency experience so these programs cannot be established exclusively in rural hospitals. Nonetheless, the commenter asked CMS to change its regulations to allow teaching hospital payment when emergency medicine residents rotate through rural hospitals.

Response: It appears that the commenter is making two separate requests; first, that some special consideration be given in redistributing slots to hospitals that are located in "designated shortage areas" and are training emergency medicine residents, and second, that CMS should change its regulations to allow a hospital that operates an emergency medicine residency program, and sends those residents to a rural hospital for some rotations, to continue to count in its direct GME and IME FTE counts the training time spent at the rural hospital. With regard to the first request, similar to the Evaluation Criterion for emergency medicine we included for the purpose of implementing section 422 of the MMA, we agree it is worthwhile to include an Evaluation Criterion regarding emergency medicine programs under section 5503 as well. Specifically, we are adding the following to this final rule: *Evaluation Criterion Eight. The hospital is requesting slots to expand an existing emergency medicine program in which the residents train in Primary Care HPSAs.* (1 Point)

To answer the second request, the prohibition against one hospital claiming the time at another hospital is based in the statute and cannot be changed without legislation. We have explained this policy numerous times in previous **Federal Register** notices (we refer readers to 67 FR 50077, August 1, 2002). This law is implemented in the regulations at section 413.78(b), which states, "A hospital cannot claim the time spent by residents training at another hospital."

Comment: One commenter expressed support for the residency slot redistributions under section 5503, but also asked that CMS reconsider the definition of primary care as it relates to section 5503. This commenter asked CMS to include adult psychiatry in the definition of primary care. This commenter noted that depression is the fourth leading cause of disability world-wide and mental illness and addictions together are the second leading cause of disability and premature mortality in the United States. Moreover, the commenter stated that national studies also suggest that two-thirds of primary care physicians report being unable to obtain outpatient mental health services for patients. The commenter also asserted that a comprehensive primary care Home Health Model will include mental health and psychiatry.

Similarly, one commenter strongly encouraged CMS to count combined residencies in internal medicine-pediatrics among the primary care residency programs eligible for additional slots under the redistribution effort. The commenter explained that internal medicine-pediatrics residencies are combined 4-year training programs in which residents experience the array of training opportunities open to residents in internal medicine and pediatrics separately. The commenter noted that Congress has treated internal medicine-pediatrics residencies unevenly over the years, including recognition as primary care residency programs in one section of the Affordable Care Act (ACA) while overlooking these residencies as primary care training experiences in other sections of the same law. Further, the commenter believed CMS has the authority to include these combined programs for these regulations.

Response: The definition of "primary care resident" is found in the statute at section 1886(h)(5)(H) of the Act, and psychiatry is not one of the specialties defined as primary care. While we acknowledge the existing shortage in the provision of mental health services, the Secretary does not have the authority to include psychiatry in the definition of primary care without a change in the law. To respond to the second commenter that requested that combined internal medicine-pediatrics programs be recognized as primary care programs eligible for slots under section 5503, we note that these programs are already considered to be primary care under section 1886(h)(5)(H) of the Act. We believe that the commenter's confusion regarding CMS's treatment of combined internal medicine-pediatrics programs may stem from the fact that the ACGME does not specifically accredit residency programs in the combined format. The ACGME separately accredits internal medicine programs and pediatrics programs. However, the ABMS recognizes combined programs, and provides board certification in both internal medicine and pediatrics for residents who train in combined internal medicine-pediatrics programs. Because both internal medicine and pediatrics programs meet the definition of primary care at section 1886(h)(5)(H) of the Act, we agree that combined internal medicine-pediatrics programs also meet the definition of primary care programs. Thus, hospitals applying for slots under section 5503 to start or expand combined internal medicine-pediatrics programs might

qualify to receive points under Evaluation Criteria Three and Four.

After consideration of the public comments we received, we are finalizing our proposed six Evaluation Criteria, and we also are adding two more Evaluation Criteria in this final rule. We are also clarifying that, because of the 75-percent threshold, a hospital cannot apply for slots under section 5503 only for a non-primary care program (other than general surgery). However, a hospital could apply for slots, and demonstrate that it needs 75 percent of those slots to start or expand a particular primary care (or general surgery) program, and that it needs 25 percent of those slots for use in a particular non-primary care program. However, the hospital's request for each program will be evaluated separately.

15. Exception If Positions Are Not Redistributed by July 1, 2011

Section 1886(h)(8)(E)(ii) of the Act states that in the case where, by July 1, 2011, the Secretary "does not distribute positions to hospitals," the Secretary shall distribute such positions to other hospitals in accordance with the considerations in redistribution specified at section 1886(h)(8)(C) of the Act (that is, the demonstrated likelihood of filling the slots and whether the hospital has a rural training track), and the priority for certain areas specified at section 1886(h)(8)(D) of the Act (that is, whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile, whether the hospital is located in a State that is in top 10 States in terms of Primary Care HPSA population to State population, and whether the hospital is rural). We believe that the phrase "does not distribute positions to hospitals" contemplates the scenario where there would be more slots available than the amount that qualifying hospitals requested, and therefore, CMS would be left with slots in the distribution pool as of July 1, 2011. The Secretary is directed to initiate another round of applications after July 1, 2011, in which hospitals that could demonstrate that they could use the slots would apply and possibly receive a portion of the remaining slots, until all the slots in the pool are redistributed. Should the situation arise where there are unused slots available as of July 1, 2011, we would propose a process for redistributing those slots "in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D)." We would then notify the public to establish the application timeframe, criteria, process and other relevant information at that time.

Comment: Several commenters addressed additional items for consideration if all of the available caps are not redistributed by July 1, 2011, using the criteria under section 5503. One commenter stated that these leftover caps should be distributed to hospitals that are currently exceeding their caps. Another commenter recommended that the Secretary broaden the redistribution criteria to ensure that all slots are filled and utilized while emphasizing the considerations made by section 5503. This commenter urged CMS to consider using a hospital's post-residency placement of residents in rural areas, and not necessarily require a certified rural training track within that hospital's GME program. This commenter also requested that the criteria listed in section 5503 be used only as guidance rather than as prescriptive criteria in the event all available caps are not distributed by July 1, 2011. This commenter also recommended that CMS use applications from the first round of redistribution and fill those slots first before proposing additional rules.

Another commenter suggested that, should slots remain in the distribution pool after the first round of applications has been processed, CMS continue down the lists of States with low resident-to-population ratios and high HPSA populations, allowing hospitals in the next several States on each list to apply for slots in a second round of applications. This commenter further stated that should a second application process occur, it should not be identical in all ways to the first round because hospitals that were unable to accommodate additional residents in the first round would not be significantly more likely to meet the same requirements in under a year from now. Additionally, another commenter suggested that if there are more slots than the anticipated demand, hospitals that do not fit into the prescribed categories should be able to apply for the additional slots.

Response: As we explained in the proposed rule (75 FR 46410), should the situation arise where there are unused slots available as of July 1, 2010, we would propose a process for redistributing those slots "in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D)." We would then notify the public to establish the application timeframe, criteria, process and other relevant information at that time. We appreciate the commenters' suggestions and will keep them in mind should the need arise to propose a second round for redistribution of unused slots.

16. Application of Direct GME PRAs for Primary Care and Nonprimary Care Residents and Conforming Changes for the IME Multiplier

Section 1886(h)(8)(G) of the Act states that, "With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital." Hospitals that receive increases in their FTE resident caps under section 1886(h)(8)(B)(i) of the Act will receive direct GME payments associated with those FTE residents in the same manner as they receive direct GME payments for their other (non-section 422) FTE residents, that is, using the primary care PRA that is reported on Worksheet E–3, Part IV, line 3.23, and the nonprimary care PRA reported on line 3.17 of the same worksheet. This provision in section 5503 differs from section 422 in that hospitals that received additional slots under section 422 receive direct GME payment for FTE residents attributable to those slots using a single locality-adjusted national average PRA (42 CFR 413.77(g)), and the payment determination is made on Worksheet E–3, Part VI. Thus, if a hospital received additional slots under section 422, and they train a number of residents that is sufficient to require them to count FTE residents under those slots, the hospital will continue to receive direct GME payment for those slots using the locality-adjusted national average PRA. However, in the August 3, 2010 proposed rule (75 FR 46410), we proposed that a hospital that receives additional slots under section 5503 would be paid for FTE residents counted under those slots using the same primary care and nonprimary PRAs for which payment is made for FTE residents subject to the 1996 FTE cap. We indicated that we are expecting to revise Worksheet E–3, Part IV to add a line on which hospitals would report the number of FTEs by which the hospital's FTE caps were increased for direct GME slots received under section 5503. (We note that on the new Medicare cost reporting form, CMS–2552–10, the direct GME worksheet is E–4). To create a hospital's total adjusted direct GME FTE cap, the increase granted under section 1886(h)(8)(B)(i) of the Act would be added to the 1996 direct GME FTE cap and would include any applicable new

program adjustment received under § 413.79(e), and any applicable adjustments for the cost reporting period due to a Medicare GME affiliation agreement. In a given cost reporting year, we proposed that a hospital would only count FTE residents under its direct GME section 422 cap slots on Worksheet E–3, Part VI if the number of unweighted allopathic and osteopathic residents it is training exceeds the total adjusted direct GME cap (including the section 5503 slots) on Worksheet E–3, Part IV.

In addition, with respect to the IME adjustment, in the August 3, 2010 proposed rule (75 FR 46410), we proposed that a hospital that receives an increase in its FTE cap under section 1886(h)(8)(B)(i) of the Act will count FTE residents under those slots, and payment will be made with respect to residents counted under those slots, using the same IME multiplier for which payment is made for FTE residents subject to the 1996 FTE cap (that is, currently a multiplier of 1.35). This is because section 1886(d)(5)(B)(x) of the Act, as added by section 5503(b)(2), states, "For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions." This provision in section 5503 differs from section 422 in that hospitals that received additional slots under section 422 receive IME payment for FTE residents counted under those slots using a special multiplier of 0.66 (42 CFR 412.105(e)(2)), and the payment determination is made on Worksheet E–3, Part VI. We also indicated that we are expecting to revise Worksheet E, Part A to add a line in which applicable hospitals would report the amount of additional IME slots received under section 5503. To create a hospital's total adjusted IME FTE cap, this additional amount would be added to the 1996 IME FTE cap, any applicable new program adjustment received under § 413.79(e), and any applicable adjustments for the period due to a Medicare GME affiliation agreement. In a given cost reporting year, we proposed that a hospital would only use its IME section 422 cap slots on Worksheet E–3, Part VI if the number of unweighted allopathic and osteopathic residents it is training exceeds the total adjusted IME cap (including the section 5503 slots) on Worksheet E, Part A. Finally, under section 422 of Public Law 108–173, hospitals that were members of the same Medicare GME affiliated group on or after July 1, 2005, and that received additional FTE cap slots under section 422 are precluded from including those additional section 422 slots in the aggregate affiliated cap. This is in part because section 422 specified that a hospital would receive direct GME and IME payments for additional slots awarded under section 422 with rates that were different from the non-section 422 cap slots, and tracking the different direct GME and IME payment rates associated with FTE residents that are counted as a result of the section 422 cap increases and those that were not would be extremely difficult for the Medicare contractors. In addition, in order to qualify for additional slots under section 422, the hospitals had to document a need for those slots. Similarly, under section 5503, we proposed that hospitals that receive additional slots under section 5503 *cannot* use these slots as part of the aggregate cap in a Medicare GME affiliation agreement. This is because we believe that once a hospital has demonstrated that it truly needs the additional slots, has made the effort to carefully document that it will fill those slots within 3 years, and once we have determined that the characteristics of the hospital and its training program warrant an increase in the hospital's FTE resident caps under section 1886(h)(8)(B)(i) of the Act, we do not believe it would be appropriate for the hospital to transfer those positions to another hospital, albeit temporarily, under the terms of a Medicare GME affiliation agreement. To do so would be to undermine the goals and specifications for the redistribution of residency positions as set forth under section 5503 of the Affordable Care Act.

We note that section 1886(h)(8)(B) of the Act, which addresses the increases in hospitals' FTE resident caps, makes no reference to section 1886(h)(4)(G) or 1886(d)(5)(B)(vi)(II) of the Act, which are the provisions concerning the rolling average count of FTE residents. Furthermore, there is no mention of section 1886(d)(5)(B)(vi)(I) of the Act, the provision regarding the cap on the IME resident-to-bed ratio, in section 1886(h)(8)(B) of the Act either. That is, the statute does not provide for an exclusion from application of the rolling average for residents counted as a result of FTE cap increases under section 1886(h)(8)(B)(i) of the Act, nor does the statute exempt the residents counted pursuant to FTE cap increases under section 1886(h)(8)(B)(i) from the application of the cap on the IME resident-to-bed ratio. In light of the absence of a specific directive in section 1886(h)(8)(B)(i) of the Act exempting those residents from application of the rolling average for direct GME and IME, and the cap on the IME resident-to-bed ratio, and with no apparent reason to treat residents counted as a result of the FTE cap increases under section 1886(h)(8)(B) of the Act differently, in the August 3, 2010 proposed rule (75 FR 46411), we proposed to require that if a hospital increases its direct GME or IME FTE count of residents under an increase in the hospital's FTE resident cap under section 1886(h)(8)(B)(i) of the Act, those FTE residents would be immediately subject to the rolling average calculation and the cap on the IME resident-to-bed ratio. Furthermore, we believe that, given potentially significant shifts of FTE resident positions among hospitals as a result of section 1886(h)(8) of the Act, the inclusion of FTE residents counted as a result of FTE cap increases under section 1886(h)(8)(B)(i) of the Act in the rolling average would introduce a measure of stability and predictability, and mitigate radical shifts in GME payments from period to period.

Comment: Commenters expressed support of the treatment of hospitals with caps that have been reduced or increased under section 422 of the MMA. However, one commenter suggested that payment levels should either be the same for all FTE cap types or that each of the three should have its own payment level to perhaps provide additional incentives for training primary care residents.

Response: Both section 422 of the MMA and section 5503 of the Affordable Care Act specify clearly which direct GME and IME payment rates are to be used.

Comment: One commenter agreed with CMS' proposal that if a hospital receives slots under 5503, and also received slots under section 422, only FTE residents in excess of the hospital's 1996 cap, as increased by the new section 5503 slots, would be paid at the section 422 payment rates (the locality-adjusted national average PRA for direct GME, and the 2.7 percent multiplier for IME).

Response: We are finalizing our proposal that only FTE residents in excess of a hospital's 1996 FTE cap, as increased by the section 5503 slots, would be paid at the section 422 rates (the locality-adjusted national average PRA for direct GME, and the 2.7 percent multiplier for IME).

Comment: Commenters disagreed with CMS' proposal to include FTE

residents added to a hospital under section 5503 in the hospital's rolling average count for IME and direct GME, and in the cap on the IRB ratio for IME. The commenters acknowledged that section 5503 is silent on this matter, but argued that the absence of language to exclude redistributed FTEs from the rolling average and IRB ratio cap need not compel CMS to include redistributed FTEs in the rolling average and IRB ratio cap. The commenters noted that CMS has used its authority in the past to create exceptions to the rolling average and IRB ratio cap when the application of these provisions would "create an unfair result" (for example, to exclude residents displaced by the closure of a hospital or residency program from a receiving hospital's rolling average or IRB ratio cap). The commenters argued that "it makes little sense" to apply the rolling average and IRB ratio cap here as well. The commenters believed that the fact that Congress wanted redistributed resident slots to be used to meet specific policy goals for a 5-year period demonstrates that Congress did not intend the usual FTE counting rules to apply to redistributed FTE slots.

Another commenter agreed with CMS' proposal to include residents added under section 5503 in the rolling average and the IME IRB ratio cap. The commenter believed that the inclusion of these FTE residents in the rolling average and IME IRB ratio cap would "introduce a level of stability in the aggregate GME payments."

Response: Regarding the applicability of the rolling average and the IRB ratio cap to redistributed slots under section 5503, we explained in the August 3, 2010 proposed rule (75 FR 46411) that, "In light of the absence of a specific directive in section 1886(h)(8)(B)(i) of the Act exempting those residents from application of the rolling average for direct GME and IME, and the cap on the IME resident-to-bed ratio, and with no apparent reason to treat residents counted as a result of the FTE cap increases under section 1886(h)(8)(B) of the Act differently, we are proposing to require that if a hospital increases its direct GME or IME FTE count of residents under an increase in the hospital's FTE resident cap under section 1886(h)(8)(B)(i) of the Act, those FTE residents would be immediately subject to the rolling average calculation and the cap on the IME resident-to-bed ratio. Furthermore, we believe that, given potentially significant shifts of FTE resident positions among hospitals as a result of section 1886(h)(8) of the Act, the inclusion of FTE residents counted as a result of FTE cap increases under section 1886(h)(8)(B)(i) of the Act in the rolling average would introduce a measure of stability and predictability, and mitigate radical shifts in GME payments from period to period." We continue to believe that it is appropriate to include these FTE slots in the rolling average and in the IRB ratio cap. In the instance of displaced residents that result from the closure of a hospital or a residency program, an exemption was provided under sections 413.79(h) for direct GME and 412.105(b) for IME regarding the rolling average and the IRB ratio cap respectively so as to provide an incentive for hospitals that may have experienced some financial loss when accepting actual residents, not merely FTEs, into their hospitals and programs who may otherwise not have been able to complete their training. Such an exception is not warranted under section 5503, where hospitals are only applying for FTE slots to either start new programs or expand existing programs. We also appreciate the support of the commenter that wrote that the inclusion of these FTE residents in the rolling average and IME IRB ratio cap would "introduce a level of stability in the aggregate GME payments." We are finalizing our proposal to include FTE slots added under section 5503 in the rolling average and IRB ratio cap accordingly.

Comment: A commenter thought that CMS should permit hospitals to use slots awarded under section 5503 as part of Medicare GME affiliation agreements after a certain period of time, such as 5 years, coinciding with the end of the time period of other restrictions applicable to slots awarded under section 5503. The commenter understood CMS' rationale for proposing to require that hospitals not include slots received as part of Medicare GME affiliation agreements, but the commenter believed that keeping separate track of these FTEs is administratively burdensome, and that circumstances can change over time. Similarly, commenters expressed concern that redistributed positions could not be aggregated under a Medicare GME affiliation agreement. Commenters stated that this limitation seems contradictory in that it allows these affiliated programs to lose slots, but not gain them when they meet the redistribution criteria. Moreover, commenters thought that this policy restricts collaborative training arrangements, which are particularly important for resident training in rural and underserved areas.

Response: In the August 3, 2010 proposed rule (75 FR 46410), we proposed that hospitals that receive additional slots under section 5503 *cannot* use these slots as part of the aggregate cap in a Medicare GME affiliation agreement. This is because we believe that once a hospital has demonstrated that it truly needs the additional slots, has made the effort to carefully document that it will fill those slots within 3 years, and once we have determined that the characteristics of the hospital and its training program warrant an increase in the hospital's FTE resident caps under section 1886(h)(8)(B)(i) of the Act, we do not believe it would be appropriate for the hospital to transfer those positions to another hospital, albeit temporarily, under the terms of a Medicare GME affiliation agreement. To do so would be to undermine the goals and specifications for the redistribution of residency positions as set forth under section 5503 of the Affordable Care Act. However, the commenters' provide a compelling argument that this limitation seems contradictory in that it allows these affiliated programs to lose slots, but not gain them when they meet the redistribution criteria. Further, we understand that training needs can change over time, and there may be a need to cross-train residents in different hospital settings. In addition, because slots received under section 5503 are to be paid with the same direct GME PRA and IME multiplier as a hospital's other residents (unlike slots received under section 422 of the MMA which are paid at different payment rates), it would not present an administrative burden to include section 5503 slots in Medicare GME affiliation agreements. Therefore, we are revising our proposal and adopting the commenters' suggestion to permit hospitals to use slots awarded under section 5503 as part of Medicare GME affiliation agreements after 5 years, which would coincide with the end of the time period of other restrictions applicable to slots awarded under section 5503. Thus, slots awarded under section 5503 could first be used (either lent or received) as part of Medicare GME affiliation agreements for the academic year beginning July 1, 2016. However, we caution that section 5503 slots that are used in Medicare GME affiliation agreements on or after July 1, 2016, are at risk for removal by the Medicare contractor from those affiliation agreements if, while auditing a cost report that falls within the 5-year period, the contractor finds that the hospital did not meet the primary care average or 75 percent threshold requirement.

After consideration of the public comments we received, we are

finalizing our proposals not to exempt slots added under section 5503 from the rolling average or the IRB ratio. However, we are accepting the commenters' request regarding use of the section 5503 slots in Medicare GME affiliation agreements, and we are modifying our proposal policy to allow these slots to be used as part of the FTE caps in Medicare GME affiliation agreements for the academic year beginning July 1, 2016.

17. Other Issues Related to a Request for Increase in the FTE Caps under Section 5503 of the Affordable Care Act

a. Rural Hospitals or Urban Nonteaching Hospitals

Rural hospitals may receive an adjustment to their FTE caps for establishing a new residency program under § 413.79(e)(1)(iii) of the existing regulations at any time. Therefore, if a rural hospital is interested in starting a new program, or interested in participating in training residents in a new program on or after July 1, 2011, it need not apply for slots under section 5503 of the Affordable Care Act for that new program. If a rural hospital seeks to expand an existing program, and does not have sufficient space under its existing FTE caps to cover those additional residents, the rural hospital may apply for an increase to its FTE caps under section 5503. Similarly, an urban hospital may request additional slots under section 5503 for the purpose of expanding an existing program. A hospital, rural or urban, that is not yet a teaching hospital and does not have a cap established, may *not* apply for a permanent adjustment to their FTE caps under section 5503 since a non-teaching hospital may apply for a permanent cap adjustment under current Medicare regulations at § 413.79(e). Also, if an urban non-teaching hospital becomes a teaching hospital because it begins to serve as a rotating site for another hospital's existing program, it may apply for additional slots under section 5503, which would not preempt the hospital from later getting a new cap adjustment under § 413.79(e) for starting a new program.

We did not receive any public comments on this section, and we are finalizing our proposals accordingly.

b. Closed Teaching Hospitals

We note that under section 5506 of the Affordable Care Act, as explained further in section XXI.E. of this preamble, the FTE resident caps of teaching hospitals that close on or after March 23, 2008, are to be redistributed to other qualifying hospitals according to specific criteria. Assuming a teaching hospital closed recently, it is possible that based on the closed teaching hospital's three most recent cost reporting periods ending prior to March 23, 2010, its FTE resident caps could be subject to reduction under section 5503. However, so as to avoid duplication of FTE resident slots in the redistribution processes under sections 5503 and 5506, in the August 3, 2010 proposed rule (75 FR 46411), we proposed that if a hospital closes on or after March 23, 2008, then its FTE resident cap slots would *not* be redistributed under section 5503, but would be reserved for redistribution under section 5506.

We received one public comment in support of this proposal, and we are finalizing our policy accordingly.

c. Requirements for Hospitals That Receive Additional Slots Under Section 5503

Section 1886(h)(8)(B)(ii) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, specifies requirements and thresholds that a hospital that applies for and receives additional slots effective July 1, 2011, must meet in order to retain those slots. Under section 422 of Public Law 108–173, hospitals that received additional slots were not held accountable for meeting any requirements once those slots were received effective July 1, 2005, nor did section 422 require that CMS conduct any subsequent reviews of the hospitals that received the slots in order to determine that the hospitals were meeting certain thresholds. However, section 1886(h)(8)(B)(ii) of the Act, as added by section 5503 of the Affordable Care Act, specifies requirements that a hospital that receives an increase in its FTE resident caps under section 1886(h)(8)(B)(i) must meet, at least for a 5-year period beginning on or after July 1, 2011, and section 1886(h)(8)(B)(iii) directs the Secretary to reduce the FTE caps of the hospital by the same number of FTE residents by which the hospital's FTE caps were increased if the hospital fails to meet these requirements. Specifically, section 1886(h)(8)(B)(ii) of the Act states, "a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

(I) The number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph; and

(II) Not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period."

Section 1886(h)(5)(H) of the Act defines "primary care resident" as a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. In the August 3, 2010 proposed rule (75 FR 46411), we proposed that a hospital that is applying to receive additional slots would have to submit data from the three most recent cost reporting periods ending before March 23, 2010 (the date of enactment) on the number of unweighted FTE residents in these primary care programs. We note that this primary care average is based on the hospital's total FTE count that would otherwise be allowable in absence of the FTE cap; if a hospital is training FTE residents in excess of its FTE caps, it would still determine the 3-year average based on the total number of unweighted primary care FTE residents. A total primary care FTE count, one for IME and one for direct GME, is sufficient for the hospital for each of these three cost reporting periods; a hospital need not report these data by specialty. However, we note that, currently, the Medicare cost report does not track a hospital's number of primary care residents. For direct GME, on Worksheet E–3, Part IV, line 3.19, the hospital's number of weighted primary care and OB/GYN residents is reported. Thus, if a hospital trains OB/GYN residents in addition to primary care residents, we proposed that the OB/GYN count must be subtracted from the number reported on line 3.19 of Worksheet E–3, Part IV for the hospital's three most recent cost reporting periods ending before March 23, 2010. This would produce a weighted FTE count for direct GME, which should then be converted to an unweighted count. In any case, the source documentation for these data is the rotation schedules for the applicable years. For IME, on Worksheet E, Part A, there is no line that currently records the number of

primary care residents, as the distinction between primary care and nonprimary care residents is only necessary in the direct GME payment formula (due to the use of a primary care and OB/GYN PRA and a nonprimary care PRA for certain years).

Therefore, in the August 3, 2010 proposed rule (75 FR 46412), we proposed that the applicant hospital must develop from its rotation schedules three IME FTE primary care counts to correspond to its three most recent cost reporting periods ending before March 23, 2010. As part of its application, we proposed that the hospital must include the documentation that it used to arrive at its direct GME and IME primary care FTE counts, including a copy of Worksheet E–3, Part IV for direct GME, and if the hospital has an OB/GYN program, the rotation schedules corresponding to the three most recent cost reporting periods ending prior to March 23, 2010 for OB/GYN, and the rotation schedules for all primary care residency programs used to establish the IME primary care FTE count corresponding to the three most recent cost reporting periods ending prior to March 23, 2010. Although we considered proposing that a hospital may demonstrate that it is complying with the requirement to maintain the primary care average with only a single unweighted FTE count, rather than one FTE count for direct GME and one FTE count for IME, we believed that we needed to propose to require documentation from both a direct GME and an IME FTE count because section 5503 of the Affordable Care Act amended section 1886(d)(5)(B)(v) of the Act to make the entire section 1886(h)(8), of which maintenance of this primary care average is a part, applicable for purposes of IME. Thus, both section 1886(h) of the Act for direct GME and section 1886(d)(5)(B) of the Act for IME are equally impacted by section 5503. Furthermore, we proposed that the FTE counts for IME and direct GME used to derive these primary care averages are subject to audit by the Medicare contractors, and that, as part of reviews or audits performed by the Medicare contractors in accordance with their normal audit plans, the Medicare contractors would check whether a hospital is maintaining its primary care average in each of the cost reports in the 5-year period as early as tentative settlement of those five respective cost reports, and may take prompt action accordingly to adjust a hospital's FTE caps and direct GME and IME interim payments.

In addition to maintaining this average number of primary care residents, section 1886(h)(8)(B)(ii)(II) of the Act also requires that a hospital that receives an increase to its FTE resident caps under section 1886(h)(8)(B)(i) of the Act must ensure that 75 percent of those slots are used to train primary care or general surgery residents. A hospital that applies for additional slots may or may not already train at least 75 percent or more of its residents in primary care or general surgery programs. At a minimum, the applicant hospital is required to maintain the average number of FTE primary care residents that it trained during the three most recent cost reporting periods ending prior to March 23, 2010. Further, in the August 3, 2010 proposed rule (75 FR 46412), we proposed that in addition to the primary care residents used to maintain the primary care average, the applicant hospital must separately ensure that at least 75 percent of the increased FTE cap slots it receives are used to count FTE residents in primary care or general surgery. We proposed that the hospital must be able to document that, during each of the 5 years in the 5-year period of July 1, 2011 to June 30, 2016, for IME and direct GME respectively, and for each cost report during those 5 years, that not only is it maintaining its primary care average, but that 75 percent of the increased FTE cap slots that it received are being used to count residents training in primary care or general surgery programs. For example, Hospital A has a June 30 fiscal year end, an FTE cap of 100 FTEs, and a total FTE count of 110. In its three most recent cost reports ending prior to March 23, 2010 (fiscal year end June 30, 2009, June 30, 2008, and June 30, 2007), Hospital A was training 60 primary care FTE residents, 50 primary care FTE residents, and 40 primary care FTE residents respectively. The average number of primary care FTE residents during those 3 years is 50. Hospital A applied for and received 10 additional FTE cap slots under section 5503. Beginning July 1, 2011, for each cost report ending June 30, 2012, June 30, 2013, June 30, 2014, June 30, 2015, and June 30, 2016, Hospital A must ensure that it does not train less than 50 primary care FTE residents, and it must ensure that it trains an additional 7.5 FTEs of the 10 slots it receives in either primary care or general surgery. In another example, Hospital B has a December 31 fiscal year end, an FTE cap of 10 FTEs, and a total FTE count of 12. In its three most recent cost reports ending prior to March 23, 2010 (fiscal year end December 31, 2009, December 31, 2008 and December 31, 2007), Hospital A was training 12 primary care FTE residents in each of the 3 years. The average number of primary care FTE residents is 12. Hospital B applied for and received 4 additional FTE cap slots under section 5503. Beginning July 1, 2011 and ending June 30, 2016, Hospital B must ensure that it does not train less than 12 primary care FTE residents, and it must ensure that it trains an additional 3 FTEs of the 4 slots it receives, for a total of 15, in either primary care or general surgery. We proposed that the Medicare contractors would check whether a hospital is maintaining this 75-percent threshold as part of reviews or audits performed by the Medicare contractors in accordance with their normal audit plans in the 5-year period as early as tentative settlement of those five respective cost reports, and may take action accordingly to adjust a hospital's FTE resident caps and direct GME and IME interim payments.

It is possible that there are hospitals that are not currently training, nor have they trained in any of their three cost reporting periods ending prior to March 23, 2010, any primary care residents at all, but that such hospitals are applying for an increase to their FTE caps for a new primary care or general surgery program that they would like to start. Such hospitals would have a primary care average of zero. Because the intent of section 5503 is to try to increase the number of primary care (or general surgery) residents in training, we proposed that such hospitals would be able to apply for additional slots under section 5503. Should such a hospital receive an FTE cap increase, we proposed that 75 percent of the increased FTE cap slots must be used to count FTE residents in either primary care or general surgery. We proposed that a hospital is required to document in each of the 5 years that it has maintained the primary care average and that at least 75 percent of the slots it receives is used for training either primary care and/or general surgery residents rather than only once at the end of the 5-year period. As explained more fully below, if a hospital has not met these requirements, in the proposed rule, we stated that we believe it would be less disruptive financially and administratively to a hospital if we make the adjustment to the hospital's FTE resident caps under section 1886(h)(8)(B)(iii)(I) of the Act and recover any overpayment after 1 year rather than after the conclusion of the

full 5 year monitoring period under section 1886(h)(8)(B)(ii) of the Act.

Section 1886(h)(8)(B)(ii) of the Act also states that "The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period" (emphasis added). In the August 3, 2010 proposed rule (75 FR 46413), we proposed that the "5-year period beginning on the date of such increase" is July 1, 2011 through June 30, 2016, because the effective date of section 5503 is for portions of cost reporting periods beginning on or after July 1, 2011. Thus, it is during this 5-year period that an "average number of full-time equivalent primary care residents" must be maintained, and that 75 percent of the additional slots must be trained in primary care or general surgery, for IME and direct GME respectively. However, the Secretary is given some discretion as to how and when she determines whether a hospital is meeting or has met the requirements "during such 5-year period." Although we believe that the 5-year period must be within July 1, 2011 through June 30, 2016, we believe we have flexibility to determine which cost reporting periods within that 5-year period we may use to assess whether the hospital is consistently meeting the required criteria. For the sake of administrative simplicity, on behalf of hospitals and the Medicare contractors, we proposed that the Medicare contractors, in accordance with their normal audit plans, would make assessments based on a hospital's fiscal year when possible, such that the Medicare contractors could make a first assessment for an initial "short" period, then annually as each of the hospital's fiscal year ends until there is another final "short" assessment period that starts after the provider's last fiscal year end within the 5-year window and runs through June 30, 2016. If a hospital has a June 30 fiscal year end, we proposed that the Medicare contractor could assess whether the hospital is meeting the required criteria five times, starting with its cost reporting period beginning on July 1, 2011, and ending with its fifth cost reporting period that starts on July 1, 2015 (and ending June 30, 2016). However, for hospitals that have a fiscal year end of other than June 30, we proposed that the Medicare contractors could assess whether the hospital met the requirements for the portion of its cost reporting period that occurs after July 1, 2011, its subsequent full cost reporting periods, and then ending with the portion of the cost reporting period prior to June 30, 2016. In other words, we proposed that the hospital would be considered to meet the required criteria in "Year 1" if it meets the requirements based on an annualized FTE count from July 1, 2011 through the end of its cost reporting period; in each of years 2 through 4, it must meet the requirements based on its next three cost reporting periods; and in year 5, it must meet the requirements based on an annualized FTE count from the first day of its cost reporting period through June 30, 2016 (which is the last day on which a hospital has any obligation to meet these requirements). For example, assume Hospital C has a September 30 fiscal year end, and receives 16 additional slots under section 5503, and has a primary care average of 30 FTE residents. We proposed that during the period of July 1, 2011 through June 30, 2016, Hospital C must demonstrate that it is training at least 75 percent of its 16 slots in primary care or general surgery (that is, 12 slots), and that it maintains a primary care FTE count of 30, as follows:

Year 1—July 1, 2011 to September 30, 2011, with an annualized count of 3 (that is, 12 divided by 4) additional FTEs in primary care/general surgery, and an annualized count of 7.5 (that is, 30 divided by 4) FTEs training in primary care residency programs.

Year 2—October 1, 2011 to September 30, 2012, with 12 FTEs in primary care/general surgery, and 30 FTEs in primary care programs.

Year 3—October 1, 2012 to September 30, 2013, with 12 FTEs in primary care/general surgery, and 30 FTEs in primary care programs.

Year 4—October 1, 2012 to September 30, 2014, with 12 FTEs in primary care/general surgery, and 30 FTEs in primary care programs.

Year 5—October 1, 2014 to September 30, 2015, with 12 FTEs in primary care/general surgery, and 30 FTEs in primary care programs.

Year 6—October 1, 2015 to June 30, 2016, with an annualized count of 9 additional FTEs in primary care/general surgery, and an annualized count of 22.5 FTEs training in primary care residency programs.

We proposed to reserve the right to assess as many times as necessary in the 5-year period that a hospital is meeting the required criteria. Furthermore, if a Medicare contractor determines during an audit that a hospital did not meet the requirements during, for example, the second year, the contractor could go back and audit the first year (full, or short period), and make a retroactive adjustment. We also understand that we should consider that hospitals might not immediately fill all the slots they receive, particularly because they are only required to demonstrate the likelihood of filling the slots within the first three cost reporting periods beginning on or after July 1, 2011. Accordingly, in the preceding example in which Hospital C was awarded 16 slots and has a September 30 fiscal year end, assume it only added 2 actual residents immediately on July 1, 2011. Two residents equate to 0.5 FTE for the 3-month period of July 1, 2011 to September 30, 2011. Seventy five percent of 0.5 FTE equals 0.375. We proposed that at least 0.375 of the new FTEs added for the period of July 1, 2011 to September 30, 2011 must be in primary care or general surgery in order to meet the requirement in "Year 1."

In a case where the Medicare contractor determines that a hospital did not meet the requirements in a cost reporting year within the 5-year time period, section 1886(h)(8)(B)(iii) of the Act states that "the Secretary shall—

(I) Reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

(II) Provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph." Hospitals have different fiscal year ends and are subject to different audit schedules, which may occur several years after a hospital's cost report is submitted. Therefore, even though we proposed that the Medicare contractors may make adjustments to a hospital's direct GME and IME payments as early as tentative settlement, it may be several years after June 30, 2016 before CMS determines the exact number of reductions, if any, that are applied to the FTE caps of hospitals that received additional slots, but that failed to meet the requirements under section 1886(h)(8)(B)(ii) of the Act, discussed above. However, once we have determined the number of slots available for a second redistribution, we would distribute them "in accordance with the requirements of this paragraph." That is, we would distribute the slots to hospitals that applied under this first redistribution and that qualified to receive the slots they requested, but for whom we did not have sufficient slots in the "pool" to grant them the full number of FTE slots that they requested. As discussed above in section XXI.D. of this preamble, because of the requirement that 70 percent of the slots be redistributed to hospitals within States with resident-to-population ratios in the lowest quartile,

it is possible that, after first distributing slots to hospitals with the highest scores on their CMS Evaluation Form, there may be some remaining qualifying hospitals within the same priority level category that receive the same score on the CMS Evaluation Form. Thus, we would have no way of distinguishing among these hospitals of equal rank. If this situation occurs, we proposed to prorate the remaining amount of slots in the "70-percent pool", and distribute an equal share of slots to these hospitals of equal rank. If a similar situation occurs within the "30-percent pool", we also proposed to prorate the remaining amount of slots in the "30-percent pool" and distribute an equal share of slots to hospitals of equal rank. Accordingly, in the event that there is a second redistribution process pursuant to section 1886(h)(8)(B)(iii)(II) of the Act, we proposed to distribute the slots in the "pool" (created by the failure of one or more hospitals to meet the criteria specified under section 1886(h)(8)(B)(ii)) of the Act to those hospitals that did not receive all of the slots for which they technically qualified, and for which we had to prorate under the first redistribution. If we have sufficient slots to fully satisfy the original requests of those qualifying hospitals, we would assign them the difference between the prorated amount awarded under the first redistribution and the amount of slots they requested on their original application (assuming they actually otherwise qualified for all the slots they requested). In other words, we would go back to the original applications and continue to assign slots to those hospitals that originally qualified to receive slots under section 5503, but for which we did not have sufficient slots to satisfy their requests. We proposed to assign the additional slots in the same priority order as under the first redistribution process under section 5503, resuming where we left off, until all the slots have been distributed. After such point, there would be no further harvesting of slots or redistribution under section 5503.

In the August 3, 2010 proposed rule (75 FR 46414), we proposed to add new regulations at § 412.105(f)(1)(iv)(C)(2) for IME and at § 413.79(n) for direct GME to reflect our proposals regarding hospitals receiving increases to their FTE resident caps under section 5503, and the requirements that hospitals must meet in order to keep those FTE slots, and not be subject to a removal of those FTE slots during the 5-year period of July 1, 2011 through June 30, 2016.

Comment: One commenter requested clarification regarding how the 5-year restrictions on the use of redistributed slots would apply to a hospital that is training residents in excess of its cap. The commenter believed that such a hospital would use the additional cap slots it receives under section 5503 for "over-the-cap" residents, as long as the hospital converts the "over-the-cap" positions to primary care or to general surgery to meet the primary care average and the 75 percent requirement.

Response: Even if a hospital that is already training residents in excess of its caps applies for additional slots, that hospital must use those cap slots in accordance with the 5-year restrictions established by section 1886(h)(8)(B)(ii) of the Act; that is, it must maintain the primary care average, and at least 75 percent of the positions must be used for additions of primary care or general surgery residents. The hospital must devote at least 75 percent of those slots to new primary care and/or general surgery programs, or to expanding existing primary care and/or general surgery programs. For example, a hospital with an FTE cap of 100 is training 50 primary care residents and 60 non-primary care residents, for a total of 110 FTE residents being trained. Assume the hospital's primary care average is also 50. The hospital receives 10 slots under section 5503, raising its FTE cap from 100 to 110. The hospital must make sure to continue to train at least 50 FTEs in primary care, excluding from this count any of the new primary care positions created under section 5503, so as to meet the primary care average requirement. That is, the hospital cannot reduce its primary care FTE count from 50 to 40, and then increase its primary care FTE count to 50 again using the 10 FTEs received under section 5503 for primary care residents in an attempt to meet the primary care average and the 75 percent requirement, because section 1886(h)(8)(B)(ii)(I) of the Act states "excluding any additional positions under subclause (II)." Rather, since the hospital received 10 slots under section 5503, the hospital must use at least 75 percent of those 10 positions, or 7.5, to either create a new or expand an existing primary care or general surgery program. If the hospital wishes to maintain training 110 FTE residents with a cap of 110, the hospital would need to eliminate 7.5 FTEs of its existing non-primary care residents, and in their place, train an *additional* 7.5 primary care or general surgery FTE residents. Assuming that the hospital chose to use the slots for primary care (and not for general surgery), the hospital would then be training 57.5 primary care FTE residents and 52.5 nonprimary care FTE residents. If the hospital does not want to reduce its non-primary care FTE count, then it would need to increase the number of residents it is training *above* 110, ensuring that it trains at least 7.5 *additional* FTEs in either primary care or surgery.

The situation is somewhat different for a hospital that is training residents in excess of its FTE resident cap, but *all* of the residents it has been training are in primary care specialties. If this hospital receives slots under section 5503, then this hospital would not need to convert any positions to primary care or general surgery, because it is already training 100 percent of its FTEs as primary care residents. It would be using 75 percent of the additional slots to start a new or expand an existing primary care or general surgery program. For example, a hospital has an FTE cap of 15, but after July 1, 2011, it is training 20 primary care FTE residents (and no other residents). Assume its primary care average is also 20 FTEs. It applies for and receives 4 slots, raising its FTE cap to 19. This hospital must continue to train 20 primary care FTE residents on or after July 1, 2011, in order to meet the primary care average requirement. Furthermore, it must use 75 percent of 4 of the slots it received (that is, 3) to train an *additional* 3 residents in primary care or general surgery programs, for a total of at least 23 primary care residents being trained (or 20 primary care in addition to 3 new surgery residents being trained).

Comment: One commenter said that CMS' proposed application of the primary care average test and the requirement that 75 percent of the slots received must be in primary care or general surgery appears "cumulative," which can lead to "absurd results." The commenter gave the following example:

The hospital has a current resident cap of 24 FTEs. For the last 3 years, the hospital has trained an average of 36 FTE residents, so it is 12 over its cap. In addition, for the last 3 years, the hospital has had an average of 36 residents in primary care, that is, 100 percent in primary care. One would think that 100 percent primary care is a good thing, but it is impossible for this hospital to change its mix to add 75 percent of its increased slots above the 3-year average in primary care.

The commenter believed this result was not required by the ACA. Specifically, section 1886(h)(8)(B)(ii) of the Act states, "a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period

beginning on the date of such increase, that—

(I) The number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), *excluding any additional positions under subclause (II)*[emphasis added by the commenter], is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph; and

(II) Not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The commenter believed that "excluding any additional positions" added for primary care means that the number of primary care positions maintained in the prior 3-year period should be determined by excluding primary care positions over the cap for which the hospital is seeking an addition to its cap. Thus, the commenter believed in the example above, the primary care average requirement would be met by the hospital continuing to train 100 percent of their FTEs as primary care residents, and the 75 percent test would be applied to residents the hospital is already training in excess of its cap.

Response: We believe the commenter has misunderstood our proposal regarding the requirements for meeting the 75 percent threshold requirement. Contrary to the commenter's assertion, the hospital in the commenter's example need not "change its mix to add 75% of its increased slots above the 3 year average in primary care." Rather, the hospital in the example is already training only primary care residents. To meet the primary care average requirement, it would not need to convert current positions to primary care. As explained in response to the previous comment, to meet the test at section 1886(h)(8)(B)(ii)(I), this hospital would need to continue to train at least 36 primary care FTE residents, and in so doing, would satisfy the primary care average requirement. In addition, to meet the 75 percent threshold requirement, the hospital will need to increase the number of residents it is training and *add* at least 9 FTEs (that is, 75 percent of 12 FTEs it receives under section 5503) for primary care or general surgery, for a total of 45 primary care residents (or a total of 36 primary care and 9 new surgery residents). This is because, under section 1886(h)(8)(B)(ii)(I) of the Act, a hospital cannot apply the positions it is using to fulfill the 75 percent threshold toward meeting the primary care average requirement. This is also consistent with the example given with Hospital B in the third column on page 46412 of the August 3, 2010 proposed rule. ["In another example, Hospital B has a December 31 fiscal year end, an FTE cap of 10 FTEs, and a total FTE count of 12. In its three most recent cost reports ending prior to March 23, 2010 (fiscal year end December 31, 2009, December 31, 2008 and December 31, 2007), Hospital A was training 12 primary care FTE residents in each of the 3 years. The average number of primary care FTE residents is 12. Hospital B applied for and received 4 additional FTE cap slots under section 5503. Beginning July 1, 2011 and ending June 30, 2016, Hospital B must ensure that it does not train less than 12 primary care FTE residents, and it must ensure that it trains an *additional* 3 FTEs of the 4 slots it receives in either primary care or general surgery. (75 FR 46412)] This means that Hospital B must *add* 3 additional FTEs *above* the 12 it is training, and those 3 FTEs would either be in primary care or general surgery.

The commenter believed that "excluding any additional positions" added for primary care means that the number of primary care positions maintained in the prior 3-year period should be determined by excluding primary care positions over the cap for which the hospital is seeking an addition to its cap. We disagree with the commenter. Knowing that the overall goal of section 5503 is to increase the number of primary care practitioners, we believe that the phrase "excluding any additional positions under subclause (II)" simply means that a hospital should not attempt to meet its primary care average requirement, which is based on *historical* numbers of primary care residents trained, by filling in the quota with *newly added* primary care positions as a result of slots received under section 5503. That is, with the primary care average requirement, Congress sought a measure of assurance that, at least with respect to hospitals that receive slots under section 5503, a relatively consistent "baseline" number of primary care residents would continue to be trained, while, through the 75 percent requirement "under subclause (II)," at least 75 percent of the redistributed slots would also be used for *additional* primary care (or general surgery) slots. To the extent that the redistributed slots must be used to create new or expand existing programs, this means that even more primary care residents above the "baseline" will be trained. That is why we proposed in the proposed rule that, "At a minimum, the applicant hospital is required to maintain the average number of FTE primary care residents that it trained during the three most recent cost reporting periods ending prior to March 23, 2010. Further, we are proposing that in addition to the primary care residents used to maintain the primary care average, the applicant hospital must separately ensure that at least 75 percent of the increased FTE cap slots it receives are used to count FTE residents in primary care or general surgery" (emphasis added, 75 FR 46412).

Comment: Commenters disagreed with CMS' proposal that hospitals that receive additional slots under section 5503 must demonstrate that for each cost report during the 5 years from July 1, 2011 through June 30, 2016, for IME and direct GME respectively, at least 75 percent of the FTE residents added in each year must be used for residents training in primary care or general surgery programs. The commenters believed this requirement is burdensome to both hospitals and contractors, and is also untenable because hospitals do not always fill all positions they offer. The commenters believe that CMS has the authority to make determinations about whether hospitals have met the 75 percent and the primary care average requirements at the end of the 5-year period: "The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period." The commenter also encouraged CMS to allow hospitals some flexibility in meeting the 75 percent requirement, because there are a number of reasons why a hospital's primary care and general surgery numbers could fluctuate slightly from year to year, including accreditation standards, fill match rates, and leaves of absence. The commenters requested that CMS find a hospital to have met the 75 percent requirement so long as the average number of residents the hospital added over the course of the 5 years is within the greater of 2 resident FTEs or 95 percent of the target number of primary care and general surgery residents. For example, if a hospital was awarded 20 new slots through the redistribution program and added an additional 20 resident FTEs, 75 percent of 20 would be 15 resident FTEs. CMS should find the hospital to have met the 75 percent requirement so long as on

average, at the end of the five year period, at least 13 of those FTE residents were training in primary care or general surgery.

Another commenter recommended that hospitals demonstrate that they met the 75 percent test over no less than 3 years. The commenter said there "is no room for mistakes under CMS' proposal." The commenter noted that FTEs are measured in fractions, and "it is conceivable that a hospital could lose additions to its cap by reason of falling short .01 of the 75 percent standard." The commenter argued that there are various reasons why a hospital might fall short of the 75 percent threshold (such as residents leaving the program due to personal or other reasons or uncertainties in rotation schedules). The commenter argued that CMS has used "multi-year measures" in other contexts, such as the 3-year rolling average for the direct GME and IME FTE count and in the context of geographic reclassification for the wage index. Therefore, particularly considering the "severe adverse consequences" that could result from the loss of additions to a hospital's cap, CMS should apply an averaging method to measuring compliance with the 75 percent test. However, one commenter applauded the 75 percent requirement and requested that CMS extend this requirement beyond 5 years, if the statute permits.

Another commenter asked that CMS allow for concessions to be made in the calculation of the average number of primary care residents that were trained in the last three cost reporting periods ending prior to March 23, 2010. The commenter stated that concessions may be necessary to account for changes in school, program(s), and rotation(s) that have occurred either during those 3 years or between the end of the last fiscal year and the time the additional slots are awarded. Some of these changes may include a closure of a program, a shifting of a rotation to another affiliated hospital, and a shifting of residents between training sites. Another commenter requested that we clarify and provide more detail regarding the repercussions to hospitals that are awarded resident slots through the redistribution program but fail to meet the 75 percent primary care/general surgery requirement or the primary care average requirement in a given hospital fiscal year.

Response: We agree with the commenters that the Secretary has the authority to make determinations about whether a hospital has met the 75 percent and the primary care average requirements at the end of the 5-year period. Section 1886(h)(8)(B)(ii)(II) of the Act states, "The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period." We stated in the proposed rule (75 FR 46413) that we believe we have the flexibility to determine which cost reporting periods within the 5-year period of July 1, 2011 to June 30, 2016 we may use to assess whether a hospital is consistently meeting the required criteria. We also proposed to reserve the right to assess as many times as necessary in the 5-year period that a hospital is meeting the criteria. Further, we also proposed that Medicare contractors, in accordance with their normal audit plans, would make assessments as to whether hospitals are meeting the criteria. Because every hospital is not audited every year, the Medicare contractor may not audit to determine if a hospital is meeting the criteria every year within the 5-year period. We believe this proposal is fair and in accordance with normal audit procedures and, therefore, we are not adopting the comments requesting that the contractors determine that hospitals met the requirements over no less than 3 years or only once at the end of the 5-year period. While we certainly note the "applause" from one commenter regarding the 75 percent threshold requirement, the statute clearly limits the "probationary period" to 5 years and, therefore, we cannot extend such monitoring beyond June 30, 2016.

We are sympathetic to the commenters' concerns that there is "no room for mistakes under CMS' proposal," and that some kind of range or "multi-year" average should be used to measure compliance with the 75 percent test. Another commenter asked that CMS allow for concessions to be made in the calculation of the average number of primary care residents that were trained in the last three cost reporting periods ending prior to March 23, 2010. We have considered whether the Secretary has the authority at all to allow for any "wiggle room" in determining whether a hospital meets the primary care average and the 75 percent threshold, and whether that authority would apply to the FTE counts on the applicable cost report being reviewed during the 5-year period, or whether, as the one commenter suggests, concessions could instead be made in the determination of the primary care average based on the cost reports that most recently ended on or before March 23, 2010. We do not believe we have flexibility to adjust the number for the primary care average or the 75-percent threshold. The statutory language stating "The number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (*as determined by the Secretary*), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph" is very specific; "close" is not close enough. Therefore, we are not adopting the commenter's request that a hospital has met the 75 percent requirement so long as the average number of residents the hospital added over the course of the 5 years is within the greater of 2 resident FTEs or 95 percent of the target number of primary care and general surgery residents. However, we believe we have the discretion to consider a hospital's performance over more than 1 year, rather than only always reviewing each year during the 5 years independently. For example, if Hospital A's GME payments are reviewed during Year 1 of the 5-year period, and Hospital A is found to not meet the primary care average or the 75 percent threshold requirement, then Hospital A would lose the slots it received under section 5503. If Hospital A has met the requirements in Year 1, it would keep the slots. If Hospital A is reviewed in Year 2, and the contractor determines that in Year 2's cost report, the primary care average or the 75 percent threshold is not met, then rather than immediately removing the slots that the hospital received, the contractor could review Year 1's and Year 2's cost reports, and average the resident counts from both years to determine if the hospital has met the criteria over a 2-year period. If, over that 2-year period, the hospital met the requirements, then the hospital would be able to keep the slots it received under section 5503. If not, then the contractor would remove the slots. Similarly, if Hospital A's GME payments are reviewed during Year 3 of the 5-year period, and the contractor determines that in Year 3's cost report, the primary care average or the 75 percent threshold is not met, then rather than immediately removing the slots that the hospital received, the contractor could review Year 1's and Year 2's cost reports, and average the resident counts from all 3 years to determine if the hospital has met the criteria over a 3-year period. If, over that 3-year period, the hospital met the requirements, then the hospital would be able to keep the

slots it received under section 5503. If not, then the contractor would remove the slots from the earliest year (that is, cost reporting period) that is reopenable in which it would be determined that the hospital did not meet the requirements. The same method could apply for reviews occurring during Years 4 and 5 of the 5-year period.

Comment: Another commenter noted that CMS proposed that Medicare contractors, in accordance with their normal audit plans, would make assessments based on a hospital's fiscal year "*when possible*" (commenter emphasis added), and as early as the tentative settlements, such that the Medicare contractors could make a first assessment for an initial short assessment period, then annually as each of the hospital's fiscal year ends until there is another final short assessment period that starts after the provider's last fiscal year end within the 5-year window and runs through June 30, 2016. The commenter stated that it is unlikely that the Medicare contractor might review a hospital's number of primary care residents as early as the tentative settlement because (1) a review of interns and residents is not part of the normal review process for a tentative settlement, and (2) this information is not on the cost report in the level of detail needed for review. The commenter expected the most likely scenario to be that a Medicare contractor would review the information, if available, at desk review (which is supposed to be within 1 year of cost report submission, for timeliness), or at audit.

Response: In the August 3, 2010 proposed rule (75 FR 46412), we proposed that "the FTE counts for IME and direct GME used to derive these primary care averages are subject to audit by the Medicare contractors, and that, as part of reviews or audits performed by the Medicare contractors in accordance with their normal audit plans, the Medicare contractors would check whether a hospital is maintaining its primary care average in each of the cost reports in the 5-year period as early as tentative settlement of those five respective cost reports, and may take prompt action accordingly to adjust a hospital's FTE caps and direct GME and IME interim payments." Under this proposal, we did not necessarily *require* the Medicare contractors to review compliance with the primary care average during every tentative settlement, and at that time, to also adjust a hospital's FTE caps and interim payments. However, it was certainly our intention to clearly state that if noncompliance was discovered, then the contractors would not need to wait until final settlement to adjust a hospital's IME and direct GME payments, but such action could occur as soon as possible. It is still our intention to clearly state that it is within CMS' and the contractors' rights to adjust a hospital's IME and direct GME payments as early as possible within a cost report's submission and review cycle, and that we would not need to wait until desk review, actual audit, or final settlement to do so. However, the commenter has prompted us to consider what documentation is actually available to the contractors at tentative settlement. When a Medicare contractor would review a hospital's data to determine whether a hospital that received slots under section 5503 is meeting the primary care average for portions of cost reporting periods occurring between July 1, 2011 and June 30, 2016, the contractor would need the documentation that the hospital used to arrive at its direct GME and IME primary care FTE counts, including a copy of Worksheet E–3, Part IV for direct GME, and if the hospital has an OB/GYN program, the rotation schedules corresponding to the three most recent cost reporting periods ending prior to March 23, 2010 for OB/GYN, and the rotation schedules for all primary care residency programs used to establish the IME primary care FTE count corresponding to the three most recent cost reporting periods ending prior to March 23, 2010. Further, the contractor would need the rotation schedules for the cost reporting period under review (that is, the portions of cost reports occurring between July 1, 2011 and June 30, 2016). We agree with the commenter that rotation schedules and other documentation generally used for verifying FTE counts are not available at tentative settlement, as such source documentation is not typically submitted with the initial cost report. Source documentation is typically requested by the contractor and submitted by the hospital when a cost report is desk reviewed or audited, which would be subsequent to tentative settlement. Accordingly, in this final rule, we are emphasizing that when a Medicare contractor reviews one or more of a hospital's cost reports within the 5-year period as explained above, the contractor may take prompt action as soon as is feasible to adjust a hospital's FTE caps and direct GME and IME payments, and need not wait until final settlement to do so.

Comment: One commenter observed that the proposed rule states that Medicare contractors will check that hospitals that receive slots under section 5503 maintain a specified level of primary care residents through their normal audit plans. The commenter pointed out that Medicare contractors do not audit each teaching hospital every year as part of their normal audit plans, and if Medicare contractors are to validate the level of primary care residents at the hospitals that received additions to their FTE caps, this would be outside of the normal audit plan.

Response: In the August 3, 2010 proposed rule (75 FR 46413), we proposed to reserve the right to assess as many times as necessary in the 5-year period that a hospital is meeting the required criteria. Furthermore, if a Medicare contractor determines during an audit that a hospital did not meet the requirements during, for example, the second year, the contractor could go back and audit the first year (full, or short period), and make a retroactive adjustment. We will be providing separate instructions to the Medicare contractors regarding the implementation of section 5503 and the 5-year probationary period.

Comment: One commenter asked if the hospital has one or more cost reporting periods in which it does not maintain the primary care resident level, and then achieves the primary care resident level in another cost reporting period, will the FTE slots be reinstated. For example, a hospital in the first year of its 5-year period meets the requirement for training primary care residents. In the second year, it does not meet the requirement, so the Medicare contractor removes the additional FTE caps from both year one and year two. However, based on the third year's average, which includes years one, two and three, the provider meets the primary care requirements. The commenter wondered if, in this example, the FTE cap would be reinstated for all three years.

The same commenter pointed out that the information required to determine the level of primary care residents is not on the Medicare cost report, as noted in the proposed rule. Therefore, the Medicare cost report is insufficient as a primary source of documentation for this purpose. The commenter recommended that CMS require hospitals that receive additional slots under section 5503 to "reconcile" the FTE counts they will report on the Medicare cost report worksheets E, Part A, and E–3, Part IV, to their primary care resident FTE counts. The commenter believed the reconciliations should be submitted to the Medicare contractors, with documentation to support the reconciliation and the

number of primary care residents being trained at the hospital each year.

Response: Once the Medicare contractor and CMS determine that a hospital has failed to meet the primary care average requirement or the 75 percent threshold between July 1, 2011 and June 30, 2016, it would lose those slots permanently and the slots would not be reinstated, even if the hospital meets the requirements in a subsequent cost reporting period. We believe that once the Secretary determines that a hospital's FTE caps should be reduced, those slots are subject to redistribution under section 1886(h)(8)(B)(iii)(II). Therefore, we are not holding those slots in reserve on the chance that the hospital may meet the requirements in a subsequent cost reporting period. Further, we believe the commenter has misunderstood how the determinations regarding whether compliance with the primary care average requirement will be achieved. In the commenter's example, the commenter hypothesizes that based on the third year's average, which includes years one, two and three (that is, in cost reporting periods *during* the 5-year probationary period), the provider meets the primary care requirements. However, determination of the primary care average is prescribed clearly in the law at section 1886(h)(8)(B)(ii)(I) as being based on "* * * the average number of full-time equivalent primary care residents (as so determined) *during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph*" (emphasis added). Thus, in fact what will happen is that the Medicare contractor will compare the primary care FTE count from a given cost reporting period between July 1, 2011 and June 30, 2016, to the primary care average number of FTE residents that was determined from averaging the primary care FTE count from *the 3 most recent cost reporting periods ending prior to March 23, 2010.* However, as we have stated in response to the previous comments requesting flexibility in the determinations regarding whether a hospital has met the primary care average requirement, if Hospital A's GME payments are reviewed during Year 3 of the 5-year period, and the contractor determines that in Year 3's cost report, the primary care average or the 75 percent threshold is not met, then rather than immediately removing the slots that the hospital received, the contractor could review Year 1's and Year 2's cost reports, and average the resident counts from all 3 years to determine if the hospital has met the criteria over a 3-year period. If, over that 3-year period, the hospital met the requirements, then the hospital would be able to keep the slots it received under section 5503. If not, then the contractor would remove the slots.

This commenter is correct that the information required to determine the level of primary care residents is not on the Medicare cost report. The commenter recommended that CMS require that hospitals that receive additional slots under section 5503 "reconcile" the FTE counts they will report on the Medicare cost report worksheets E, Part A, and E–3, Part IV, to their primary care resident FTE counts, and that the reconciliations should be submitted to the Medicare contractors, with documentation to support the reconciliation and the number of primary care residents being trained at the hospital each year. As we stated in response to a previous comment, when a Medicare contractor would review a hospital's data to determine whether a hospital that received slots under section 5503 is meeting the primary care average for portions of cost reporting periods occurring between July 1, 2011 and June 30, 2016, the contractor would need the documentation that the hospital used to arrive at its direct GME and IME primary care FTE counts, including a copy of Worksheet E–3, Part IV for direct GME, and if the hospital has an OB/GYN program, the rotation schedules corresponding to the three most recent cost reporting periods ending prior to March 23, 2010 for OB/GYN, and the rotation schedules for all primary care residency programs used to establish the IME primary care FTE count corresponding to the three most recent cost reporting periods ending prior to March 23, 2010. Further, the contractor would need the rotation schedules for the cost reporting period under review (that is, the portions of cost reports occurring between July 1, 2011 and June 30, 2016). We believe that contractors and hospitals should follow normal cost report and documentation submission requirements in this regard. As with other audit and reimbursement issues, hospitals are required to have documentation available and provide that documentation to the contractor upon request. The same would apply with the aforementioned required GME documentation so that the contractors may review a hospital's compliance with section 1886(h)(8)(B)(ii) of the Act.

Lastly, as stated previously in section XXI.D.12. of this final rule, we are clarifying in this final rule that "* * * the average number of full-time equivalent primary care residents (as so determined) during the three most recent cost reporting periods ending prior to the date of enactment of this paragraph" means the three most recent cost reports submitted to the Medicare contractor by March 23, 2010.

Comment: One commenter stated that some teaching hospitals that were awarded positions under section 422 of the MMA on the basis of qualifying to start or augment a residency program in one specialty actually used the acquired slots for other programs. The commenter asked CMS to explain in the final rule how the Agency will ensure that the awards actually go to create primary care slots.

Response: As we explained on page 46411 of the proposed rule, section 422 of Public Law 108–173 did not hold hospitals that received slots accountable for meeting any requirements once those slots were received effective July 1, 2005, nor did section 422 require CMS to conduct subsequent reviews of the hospitals that received slots in order to determine if the hospitals were meeting certain thresholds. However, section 1886(h)(8)(B)(ii) of the Act, as amended by the Affordable Care Act, specifically requires a hospital that receives slots under this provision to meet certain thresholds regarding training of primary care and/or general surgery residents for a period of 5 years. As we explained in the proposed rule and in this final rule, the Medicare contractors will perform reviews or audits to determine whether hospitals that received slots under section 1886(h)(8)(B)(i) of the Act are meeting those thresholds under section 1886(h)(8)(B)(ii) of the Act, and if not, those slots will be removed and redistributed in accordance with section 1886(h)(8)(B)(iii) of the Act.

Comment: One commenter argued that the preclusion on administrative and judicial review does not apply to audits that the Medicare contractors will complete, either every 5 years, or at the end of the 5-year period, and therefore, hospitals should have the opportunity to demonstrate that they met the requirements for how slots received under section 5503 must be used. Another commenter noted that CMS stated that determinations of the FTE cap reductions may not be subject to appeal. However, these FTE cap additions and reductions are reported on the Medicare cost report, which is subject to appeal.

Response: Section 5503(a)(3) of the Affordable Care Act amended section 1886(h)(7) of the Act to insert "or paragraph (8)" into paragraph (E), which, as amended, precludes administrative or judicial review "with respect to determinations made under

this paragraph, paragraph (8) * * *." (This sentence was subsequently amended by section 5506(e) as "this paragraph, paragraph (8), or paragraph (4)(H)(vi))." We believe that this amendment refers to the entirety of sections 1886(h)(7) and (h)(8) of the Act, respectively, which would include determinations regarding the FTE cap reductions, increases, whether a hospital meets the requirements during the 5-year "probationary" period, and finally, the redistribution of those positions if a hospital no longer meets those requirements. Further, we note that section 1886(h)(8)(B)(ii) of the Act states, "The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period *in such manner* and at such time *as the Secretary determines appropriate* * * *" (emphasis added). Therefore, we disagree with the first commenter and we believe that the preclusion of administrative and judicial review even applies to determinations made regarding whether a hospital meets the requirements in the 5-year "probationary" period; that is, whether the slots awarded to a hospital under section 1886(h)(8)(B)(i) of the Act are to be removed and redistributed due to failure to meet the requirements at section 1886(h)(8)(B)(ii) of the Act. However, because, as the second commenter points out, the Medicare cost reports are subject to appeal, a hospital could appeal its FTE count on a cost report occurring between July 1, 2011 and June 30, 2016. To the extent that this FTE count is at the center of a dispute as to whether the requirements at section 1886(h)(8)(B)(ii) of the Act are met, we do not believe that this should affect a final determination as to whether the requirements at section 1886(h)(8)(B)(ii) are actually met. As we clarified in this final rule, even though we are proposing that the Medicare contractors may make adjustments to a hospital's direct GME and IME payments as early as is feasible, it may be several years after June 30, 2016 before CMS determines the exact number of reductions, if any, that are applied to the FTE caps of hospitals that received additional slots, but that failed to meet the requirements under section 1886(h)(8)(B)(ii) of the Act * * *." This is because under normal audit work plans, it often takes several years from an initial submission of a cost report to final settlement. However, if the Notice of Program Reimbursement (NPR) is issued by the contractor to the hospital, final settling that cost report, and as part of that final settlement, the contractor determined that the hospital's primary care FTE count in that cost report was less than the primary care average, or that less than 75 percent of the hospital's FTE count was used to train primary care or general surgery residents, that determination is not subject to administrative or judicial review—it is a final determination. This determination that the requirements at section 1886(h)(8)(B)(ii) of the Act are not met, in turn, would trigger the determinations regarding the reduction and the redistribution of the awarded positions. These latter determinations are also not subject to administrative or judicial review. It is true that the cost report in which those determinations were made is appealable under normal procedures. Even if the outcome of the appeal, which could occur a number of years after the initial NPR, would be in favor of the hospital, raising its primary care FTE count in that year, for example, this would have no effect on the determination already made years before that the hospital did not meet the requirements at section 1886(h)(8)(B)(ii) of the Act. The outcome of the appeal could only affect IME and direct GME payment in that particular cost reporting year, but would not affect payments or FTE caps in subsequent cost reports.

After consideration of the public comments we received, we are clarifying that a hospital cannot use section 5503 slots for cap relief only; the hospital must use those cap slots to train more primary care or general surgery residents, or reduce its number of non-primary care residents, in accordance with the 75-percent threshold requirement. We also do not believe we have flexibility to adjust the number for the primary care average or the 75-percent threshold. Therefore, we are not adopting the commenter's request that a hospital has met the 75-percent requirement so long as the average number of residents the hospital added over the course of the 5 years is within the greater of 2 resident FTEs or 95 percent of the target number of primary care and general surgery residents. However, we believe we have the discretion to consider a hospital's performance over more than 1 year as to whether or not the primary care average and 75 percent threshold is met, although we believe we also maintain the authority to review each year during the 5 years independently as well. We are modifying our proposal accordingly.

We are also clearly stating in this final rule that it is within CMS' and the contractors' rights to adjust a hospital's IME and direct GME payments as early as is feasible within a cost report's submission and review cycle, and that we need not wait until final settlement to do so. Finally, we are clarifying that the determination of the primary care average is prescribed clearly in the law at section 1886(h)(8)(B)(ii)(I) of the Act as being based on "* * * the average number of full-time equivalent primary care residents (as so determined) during the three most recent cost reporting periods ending prior to the date of enactment of this paragraph" means the three most recent cost reporting periods submitted to the Medicare contractor by March 23, 2010.

d. No Administrative or Judicial Review

Section 5503(a)(3) of the Affordable Care Act amended section 1886(h)(7)(E) of the Act by adding "or paragraph (8)" such that section 1886(h)(7)(E) of the Act now specifies that "There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this paragraph or paragraph (8)" (and then further amended to include paragraph (4)(H)(vi)). As stated in the preceding section regarding reference cost reports that are under appeal, we believe the fact that Congress included this language clearly means that the Congress intended for our determination with regard to FTE resident cap reductions and redistributions under sections 1886(h)(8)(A) and (h)(8)(B) to be final, and not subject to appeal. Because of this statutory language, together with the requirement that all reductions and increases in FTE resident caps be made effective July 1, 2011, we do not believe it would be appropriate to allow hospitals (or CMS) to appeal determinations concerning the FTE cap reductions or the FTE cap increases) under section 1886(h)(8) of the Act. In addition, as indicated previously, we believe that Congress intended this provision to be implemented fairly, but efficiently, avoiding the delays and uncertainty that would be produced by an appeals process. Furthermore, we note that, as explained previously in this preamble, as was done under section 422 of Public Law 108–173, Medicare contractors will provide hospitals with a time-limited opportunity to review cap reduction determinations for possible technical errors before they are finalized.

We did not receive any public comments on this section, and we are finalizing our proposal accordingly.

The following are miscellaneous public comments we received on section 5503 and our responses to them.

Comment: Several commenters expressed general support for the redistribution of resident slots through section 5503. Many commenters agreed

that redistribution preference given to hospitals in a State whose resident-to-population ratio is within the lowest quartile and hospitals in the top 10 States/territories/districts in terms of primary care HPSA to population ratios is appropriate. One commenter wrote that "we believe the distribution of these unused medical education slots will help us maintain, even increase, the number of family practice physicians we can train." Another commenter considered these residency slot redistributions to be positive developments in the effort to improve the physician workforce shortage in rural areas. Although many commenters expressed general support for these policies, several commenters also mentioned that additional efforts will be necessary to meet the nationwide need for resident slots.

Response: We appreciate the commenters' support for our proposals.

Comment: One commenter asked that CMS clarify whether there is any relationship between the section 5503 redistribution program and the rules for counting residents for the IME teaching adjustments under the psychiatric or rehabilitation PPSs.

Response: Section 5503(a) amended section 1886(h) of the Act, which covers direct GME payments to hospitals paid under the IPPS or other hospital PPSs, which are the Inpatient Rehabilitation Facility (IRF) PPS, the Inpatient Psychiatric Facility (IPF) PPS, and the Long Term Care Hospital (LTCH) PPS. However, section 5503(b) amended section 1886(d)(5)(B)(v) of the Act for IPPS IME purposes. Therefore, the IME FTE cap reductions and increases under section 5503 only apply to "subsection (d)" IPPS hospitals. Section 5503 has no applicability to the IME teaching adjustments under the IRF PPS or the IPF PPS.

Comment: One commenter generally urged CMS to proceed with caution in the development of the final rule and to implement regulations that minimize, to the extent possible, the administrative burden associated with those requirements.

Response: We are sensitive to the documentation burdens which hospitals have, and despite the exemption of section 5503 from the Paperwork Reduction requirements, we have attempted to require documentation that is crucial for us to implement this provision in as fair and effective manner as possible.

ADDENDUM

TRAINEES IN OSTEOPATHIC PROGRAMS AS REPORTED BY STATE—2009–2010

State	Internship Programs			Residency Programs			Total		
	Programs	Positions	Trainees	Programs	Positions	Trainees	Programs	Positions	Trainees
Alabama ...	0	0	0	1	18	0	1	18	0
Alaska	0	0	0	1	9	9	1	9	9
Arizona	0	0	0	8	81	39	8	81	39
Arkansas ..	0	0	0	2	15	2	2	15	2
California ..	6	75	31	25	309	191	31	384	222
Colorado ...	1	4	3	1	9	0	2	13	3
Connecticut	1	12	1	1	11	3	2	23	4
Delaware ..	1	15	10	1	24	8	2	39	18
Florida	10	124	45	47	536	327	57	660	372
Georgia	1	4	3	3	29	18	4	33	21
Illinois	6	41	29	39	427	293	45	468	322
Indiana	1	3	1	4	30	21	5	33	22
Iowa	0	0	0	4	40	28	4	40	28
Kansas	0	0	0	1	12	11	1	12	11
Kentucky ..	2	9	3	6	42	18	8	51	21
Maine	0	0	0	7	76	42	7	76	42
Massachusetts	2	10	5	2	12	10	4	22	15
Michigan ...	20	213	92	185	1878	1289	205	2091	1381
Minnesota	0	0	0	2	14	10	2	14	10
Mississippi	0	0	0	2	24	6	2	24	6
Missouri	3	15	5	21	163	116	24	178	121
Nevada	1	15	13	6	85	57	7	100	70
New Jersey	6	57	21	54	595	350	60	652	371
New York	19	212	89	64	845	507	83	1057	596
North Carolina	2	17	0	3	33	11	5	50	11
Ohio	11	105	42	100	872	589	111	977	631
Oklahoma	2	16	7	28	291	130	30	307	137
Oregon	1	6	0	8	61	11	9	67	11
Pennsylvania	32	263	124	99	1190	770	131	1453	894
Rhode Island	0	0	0	4	50	23	4	50	23
South Carolina	0	0	0	1	14	15	1	14	15
Tennessee	0	0	0	3	33	13	3	33	13
Texas	4	32	13	23	194	107	27	226	120
Virginia	3	33	5	14	207	72	17	240	77
Washington	0	0	0	1	6	5	1	6	5
West Virginia	7	37	16	18	208	111	25	245	127

TRAINEES IN OSTEOPATHIC PROGRAMS AS REPORTED BY STATE—2009–2010—Continued

State	Internship Programs			Residency Programs			Total		
	Programs	Positions	Trainees	Programs	Positions	Trainees	Programs	Positions	Trainees
Wisconsin	0	0	0	2	46	31	2	46	31
Wyoming ..	0	0	0	1	12	4	1	12	4
Total ..	142	1,318	558	792	8,501	5,247	934	9,819	5,805

Source: The American Osteopathic Association.

BILLING CODE 4120–01–P

CMS Evaluation Form

As Part of the Application for the Increase in a Hospital's FTE Cap(s) under Section 5503 of the Affordable Care Act

Directions: Please fill out the information below for each residency program for which the applicant hospital intends to use the increase in its FTE cap(s). The applicant hospital is responsible for complying with the other requirements listed in the CY 2011 Hospital Outpatient Prospective Payment System Final Rule in order to complete its application for the increase in its FTE cap(s) under section 5503 of the Affordable Care Act, Pub. L. 111-148.

NAME OF HOSPITAL: _____

MEDICARE PROVIDER NUMBER: _____

NAME OF MEDICARE CONTRACTOR: _____

NAME OF SPECIALTY TRAINING PROGRAM: _____

(Check one): □ Allopathic Program □ Osteopathic Program

NUMBER OF FTE SLOTS REQUESTED FOR PROGRAM:

Direct GME: _____ **IME:** _____

Section A: Demonstrated Likelihood of Filling the FTE Slots

(Place an "X" in the box for the applicable criterion and subcriterion.)

□ A1: Demonstrated Likelihood Criterion 1. The hospital is training residents in excess of its FTE resident cap(s), or does not have sufficient room under its current FTE cap(s), and the hospital intends to use the additional FTEs for a new residency program that it intends to start on or after July 1, 2011 (that is, a newly approved program that begins training residents at any point within the hospital's first three cost reporting periods beginning on or after July 1, 2011). Under this criterion, the hospital must select one of the following:

(1) Hospital will establish a newly approved residency program. (Under this selection, the hospital must check at least one of the following, if applicable):

□ Application for approval of the new residency program has been submitted to the ACGME, AOA, or the ABMS by January 21, 2011. (The hospital must attach a copy.)

□ The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program by January 21, 2011. (The hospital must attach a copy.)

□ The hospital has received written correspondence from the ACGME, AOA, or ABMS acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). (The hospital must attach a copy.)

□ The hospital may submit documentation demonstrating that it has made a commitment to start a new program.

(2) Hospital will likely fill the slots requested. (The hospital must select at least one of the following, if applicable.)

□ The hospital does not have sufficient room under its FTE cap, or is exceeding its FTE cap, and the hospital's existing residency programs had a combined resident fill rate of at least 85 percent in each of program years 2007 through 2009. (The hospital must attach documentation.)

□ The hospital does not have sufficient room under its FTE cap, or is exceeding its FTE cap, and the specialty program for which the hospital is applying has a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. (The hospital must attach documentation.)

□ The hospital is training residents in excess of its direct GME FTE cap, or IME FTE cap, or both. The hospital must submit a copy of the Medicare cost report that has been most recently submitted to the Medicare contractor by March 23, 2010, documenting on Worksheet E, Part A, Worksheet E-3, Part IV, and Worksheet E-3, Part VI, the resident counts and FTE resident caps for both direct GME and IME.

□ A2: Demonstrated Likelihood Criterion 2. The hospital is training residents in excess of its FTE cap(s), or does not have sufficient room under its FTE cap(s), and the hospital intends to use the additional FTEs to expand an existing residency training program within the hospital's first three cost reporting periods beginning on or after July 1, 2011.

(1) Hospital intends to expand an existing program. Under this selection, the hospital must check at least one of the following, if applicable:

□ The appropriate accrediting body (the ACGME, AOA, or ABMS) has approved the hospital's expansion of the number of FTE residents in the program. (The hospital must attach documentation.)

□ The American Osteopathic Association Residency Match Program has accepted or will be accepting the hospital's participation in the match for the existing program that will include additional resident slots in that residency training program. (The hospital must attach documentation.)

□ The hospital has submitted an institutional review document or program information form for the expansion of the existing residency training program by January 21, 2011. (The hospital must attach documentation.)

(2) Hospital will likely fill the slots of the expanded existing residency program. Under this selection, the hospital must check at least one of the following, if applicable:

□ The hospital does not have sufficient room under its FTE cap, or is exceeding its FTE cap, and the hospital has other previously established residency programs, with a resident fill rate of at least 85 percent in each of program years 2007 through 2009.) (The hospital must attach documentation.)

□ The hospital does not have sufficient room under its FTE cap, or is exceeding its FTE cap, and the hospital is expanding an existing program in a particular specialty with a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. (The hospital must attach documentation.)

□ The hospital is training residents in excess of its direct GME FTE cap, or IME FTE cap, or both. The hospital must submit a copy of the Medicare cost report that has been most recently submitted to the Medicare contractor by March 23, 2010, documenting on Worksheet E, Part A, Worksheet E-3, Part IV, and Worksheet E-3, Part VI, the resident counts and FTE resident caps for both direct GME and IME.

Section B. Level Priority Category

(Place an "X" in the appropriate box that is applicable to the level priority category that describes the applicant hospital.)

- *First Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND it is an urban hospital that has or will have as of July 1, 2011, a rural training track.

- *Second Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile.
- *Third Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND the hospital is an urban hospital that has or will have as of July 1, 2011, a rural training track.
- *Fourth Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, OR the hospital is located in a rural area.

Section C. Evaluation Criteria

(Place an "X" in the box for each criterion that is appropriate for the applicant hospital and for the program for which the increase in the FTE cap is requested.)

- Evaluation Criterion One. *The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report.* 5 POINTS.

- Evaluation Criterion Two. *The hospital will use additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program.* 5 POINTS.

- Evaluation Criterion Three. *The hospital will use additional slots to establish a new or expand an existing primary care program with a demonstrated focus on training residents to pursue careers in primary care, rather than in non-primary subspecialties of those primary care programs (for example, the hospital has an internal medicine program with a designated primary care track).* 3 POINTS.

- Evaluation Criterion Four. *The hospital will use all the additional slots to establish a new or expand an existing primary care residency program or general surgery program*. – 5 POINTS.

- Evaluation Criterion Five. *The hospital is located in a Primary Care HPSA.* 2 POINTS.

• Evaluation Criterion Six. *The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is or will be on or after July 1, 2011, a training site for a rural track residency program (as specified under §413.79(k)), but is unable to count all of the FTE residents training in the rural track because the rural hospital's FTE cap is lower than its unweighted count of allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011.* 1 POINT.

• Evaluation Criterion Seven. *The hospital is requesting slots to expand an existing program(s) for which the hospital can demonstrate that more than 50 percent of residents completing the program(s) go on to practice in a rural area or a Primary Care HPSA or a Medically Underserved Area (MUA)* 1 POINT.

• Evaluation Criterion Eight. *The hospital is requesting slots to expand an existing emergency medicine program in which the residents train in Primary Care HPSAs*. 1 POINT.

BILLING CODE 4120–01–C

Application Process and CMS Central Office and Regional Office Mailing Addresses for Receiving Increases in FTE Resident Caps

In order for hospitals to be considered for increases in their FTE resident caps, each qualifying hospital must submit a timely application. The following information must be submitted on applications to receive an increase in FTE resident caps:

• The name and Medicare provider number of the hospital.

• The name of the Medicare contractor to which the hospital submits its Medicare cost report.

• The total number of requested FTE resident slots for direct GME or IME, or both, up to 75 direct GME FTE and 75 IME FTE per hospital.

• A completed copy of the CMS Evaluation Form for each residency program for which the hospital intends to use the requested increase in FTE residents.

• Source documentation to support the assertions made by the hospital on the CMS Evaluation Form.

• FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent cost report submitted to the Medicare contractor by March 23, 2010. (Include copies of Worksheets E, Part A, E–3, Part IV, and if a hospital received an increase to its FTE cap(s) under section 422 of the MMA, a copy of E–3, Part VI).

• As part of its application, for purposes of computing the primary care average under section 1886(h)(8)(B)(ii)(I) of the Affordable Care Act, the hospital must include the documentation that it used to arrive at its direct GME and IME primary care FTE counts, including a copy of Worksheet E–3, Part IV for direct GME, and if the hospital has an OB/GYN program, the rotation schedules corresponding to the three most recent cost reporting periods ending prior to March 23, 2010 (and submitted to the Medicare contractor by March 23, 2010) for OB/GYN, and the rotation schedules for all primary care residency programs used to establish the IME primary care FTE count corresponding to the three most recent cost reporting periods ending prior to March 23, 2010.

• An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, of the following information:

"I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil, and administrative action, fines and/or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents."

The completed application and supporting documentation (as described above) must be submitted to the CMS Central Office and the CMS Regional Office for the region in which the applicant hospital is located. The application must be received on or before January 21, 2011. The addresses of the CMS Central Office and Regional Offices are listed below.

CMS Central and CMS Regional Office Mailing Addresses for Applications for Increases in FTE Resident Caps

Central Office

Centers for Medicare and Medicaid Services (CMS), Director, Division of Acute Care, 7500 Security Boulevard, Mail Stop C4–08–06, Baltimore, Maryland 21244, (410) 786–4548.

Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region I, JFK Federal Building, Room 23275, Boston, MA 02203, Phone: (617) 565–1331.

Region II (New York, New Jersey, U.S. Virgin Islands, and Puerto Rico)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region II, 26 Federal Plaza, 38th Floor, New York, NY 10278, Phone: (212) 616–2545.

Region III (Delaware, Maryland, Pennsylvania, Virginia and West Virginia, and the District of Columbia)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region III, Public Ledger

Building, Suite 216, 150 South Independence Mall West, Philadelphia, PA 19106, Phone: (215) 861–4140.

Region IV (Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region IV, Atlanta Federal Center, 61 Forsyth Street, SW., Suite 4T20, Atlanta, GA 30303–8909, Phone: (404) 562–7300.

Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region V, 233 North Michigan Avenue, Suite 600, Chicago, IL 60601, Phone: (312) 886–6432.

Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region VI, 1301 Young Street, Suite 714, Dallas, TX 75202, Phone: (214) 767–6423.

Region VII (Iowa, Kansas, Missouri, and Nebraska)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region VII, Richard Bolling Federal Building, Room 235, 601 East 12th Street, Kansas City, MO 64106, (816) 564–1843.

Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region VIII, Colorado State Bank Building, 1600 Broadway, Suite 700, Denver, CO 80202, Phone: (303) 844–2111.

Region IX (Arizona, California, Hawaii, and Nevada and Territories of American Samoa, Guam and the Commonwealth of the Northern Mariana Islands)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region IX, 90 7th Street, Suite 5–300 (SW), San Francisco, CA 94103–6708, Phone: (415) 744–3501.

Region X (Alaska, Idaho, Oregon, and Washington)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region X, 2201 Sixth Avenue, MS/RX–46, Seattle, WA 98121, Phone (206) 615–2094.

E. Preservation of Resident Cap Positions From Closed Hospitals (Section 5506 of the Affordable Care Act)

1. Background

As we explain in section XXI.A. of this preamble, Medicare makes both direct GME and IME payments to hospitals that train residents in approved medical residency training programs. Direct GME payments are made in accordance with section 1886(h) of the Act, based generally on hospital-specific PRAs, the number of FTE residents a hospital trains, and the hospital's Medicare patient share. IME payments are made in accordance with section 1886(d)(5)(B) of the Act, based generally on the ratio of the hospital's FTE residents to the number of hospital beds. Accordingly, the calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count; generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. In an attempt to end the implicit incentive for hospitals to increase the number of FTE residents, Congress instituted a cap on the number of allopathic and osteopathic residents a hospital is allowed to count for direct GME and IME purposes under the provisions of section 1886(h)(4)(F) of the Act for direct GME and section 1886(d)(5)(B)(v) of the Act for IME. Dental and podiatric residents were not included in this statutorily mandated cap. For most hospitals, the limit, or cap, is the unweighted number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996. Thus, each teaching hospital's FTE resident cap is unique to the number of FTE residents that it trained in the hospital's most recent cost reporting period ending on or before December 31, 1996.

Under existing regulations at § 413.79(h) for direct GME and § 412.105(f)(1)(ix) for IME, a hospital that is training FTE residents at or in excess of its FTE resident caps and takes in residents displaced by the closure of another teaching hospital may receive a temporary increase to its FTE residents caps so that it may receive direct GME and IME payment associated with those displaced FTE residents. However, those temporary FTE resident cap increases are associated with those specific displaced FTE residents, and the increases expire as those displaced residents complete their training program. Thus, if a teaching hospital closes, its direct GME and IME FTE resident cap slots would be "lost," because those cap slots are associated with a specific hospital's Medicare provider agreement, which would be retired upon the hospital's closure. The closure of a teaching hospital, particularly if it is a large academic medical center, could mean not only the displacement of hundreds of residents, but also the permanent loss of hundreds of Medicare-funded residency training slots and a sophisticated GME infrastructure that could take many years to rebuild, threatening the availability of health care services in a community. Section 5506 of the Affordable Care Act addresses this situation by amending section 1886(h)(4)(H) of the Act to add a new clause (vi) that instructs the Secretary to establish a process by regulation under which, in the event a teaching hospital closes, the Secretary will permanently increase the FTE resident caps for hospitals that meet certain criteria by the number of FTE resident positions in the closed hospital's training programs.

Section 5506 of the Affordable Care Act specifically instructs the Secretary to increase the FTE resident caps for other hospitals based upon the FTE resident positions in teaching hospitals that closed "on or after a date that is 2 years before the date of enactment" (that is, March 23, 2008). Although certain of the FTE cap increases granted pursuant to section 5506 will be based on hospital closures that occurred prior to this notice and comment rulemaking procedure, we indicated in the August 3, 2010 proposed rule that the process we proposed to establish in the final rule would also be used for all future teaching hospital closures. We indicated that we were in the process of instructing the Medicare contractors to notify us of every teaching hospital that has closed since March 23, 2008, and of the direct GME and IME FTE caps for each of those closed hospitals. We plan to use this information to determine how many slots are currently available for increases to other hospitals' FTE resident caps.

We note that section 1886(h)(4)(H)(vi)(IV) of the Act, as

added by section 5506(a) of the Affordable Care Act, states that "The aggregate number of increases in the otherwise applicable resident limits for the hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after" March 23, 2008. For purposes of implementing this section 1886(h)(4)(H)(vi)(IV) of the Act, in the August 3, 2010 proposed rule (75 FR 46421), we proposed to interpret "the number of resident positions" to mean the number that is equal to the IME and direct GME FTE resident caps of a hospital that closed, or will close. We do not believe the intent of this provision is to distribute and pay for more FTE resident slots than the amount equal to a closed hospital's IME and direct GME FTE resident caps, in the instance where a closed hospital was training more FTE residents than its FTE resident caps. Further, in the situation where a closed hospital was training FTE residents below its caps, we believe that for the sake of ensuring that a community could retain up to its full training strength, we believe it is appropriate to distribute, not the actual number of slots the closed hospital had been training prior to its closure, but the number of FTE resident slots equal to the IME and direct GME FTE caps of the closed hospital.

2. Definition of a "Closed Hospital"

Section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, states that "the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program *closes* on or after" March 23, 2008, the Secretary shall increase the FTE resident caps of other hospitals accordingly (emphasis added). Under existing regulations at § 489.52 and § 413.79(h), "closure of a hospital" means the hospital terminates its Medicare provider agreement. In the August 3, 2010 proposed rule (75 FR 46421 and 46422), we proposed to define a "closed teaching hospital" for purposes of section 5506 in a similar manner, but would also specify that the FTE resident cap slots of the hospital that closed no longer exist as part of any other hospital's permanent FTE resident cap. Thus, we proposed that this provision would not apply to hospitals that declare bankruptcy but are still participating under the same Medicare provider agreement, nor would it apply to teaching hospitals that remain open, but close one or more residency programs. It also would not apply to mergers, because in the case of a merger, the Medicare provider agreement of one hospital is subsumed into the provider agreement of the surviving provider; no provider agreement is retired, even if operations at one facility are scaled back or ceased.

However, we proposed that the proposed revised definition of hospital closure for purposes of implementing section 5506 *would* apply in the case of acquisitions, where the new owner voluntarily terminates the Medicare provider agreement of the hospital it purchased by rejecting assignment of the previous owners' provider agreement, thus abdicating the FTE resident cap slots associated with that provider agreement, even if the new owner will continue to operate the hospital exactly as it had been operated before the acquisition (that is, makes no changes to the bed size, infrastructure, services, and GME programs). We believe this is appropriate because section 5506 of the Affordable Care Act specifically addresses hospital "closure" and ensures preservation of the FTE cap slots within a community when a teaching hospital does "close," based on specified criteria for redistributing the slots from the closed hospital to increase the FTE caps for other hospitals. However, as we explain further below, it is possible for the new hospital formed in an acquisition to receive preference in receiving an increase to its FTE resident caps based on redistributed slots from the closed hospital that it acquired.

Section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a), also states that "the Secretary shall, by regulation, establish a process under which, in the case where a hospital *(other than a hospital described in clause (v))* with an approved medical residency program closes * * *" (emphasis added). A hospital described in section 1886(h)(4)(H)(v) of the Act is an entity that enters into a provider agreement pursuant to section 1866(a) of the Act to provide hospital services on the same physical site previously used by Medicare Provider No. 05–0578. Accordingly, we proposed not to redistribute any FTE cap slots associated with Medicare Provider Number 05–0578.

Comment: One commenter noted that CMS proposed to define a closed teaching hospital for purposes of section 5506 as a hospital (a) that terminates its Medicare provider agreement, and (b) whose cap slots no longer exist as part of any other hospital's permanent FTE resident cap. The commenter asked CMS to clarify situations in which a hospital's Medicare provider agreement would be terminated but whose slots would still exist as part of another hospital's permanent FTE resident cap. The commenter also observed that the existing regulations text regarding the definition of hospital closure at §§ 413.79(h) and 489.52 do not indicate the concept that caps of a closed teaching hospital no longer exist as part of another hospital's permanent FTE resident cap.

Another commenter noted the provision authorizing the redistribution of residency slots would apply, however, in the case of an acquisition wherein the new owner voluntarily terminates the provider agreement of the hospital it purchased, "even if the new owner will continue to operate the hospital exactly as it had been operated before the acquisition (that is, make no changes to the bed size, infrastructure, services, and GME programs)." The commenter understood that CMS would propose this because "(1) CMS does not view this situation as a merger of two hospitals under its current policy, and (2) CMS has proposed a separate process whereby this situation could be addressed (within Ranking Criterion #1)." The commenter requested confirmation of its understanding of this policy proposal. Another commenter also commented on this issue and appreciates the extension of the definition of a closed hospital to include acquisitions.

Response: We regret that there was confusion regarding the definition of a closed hospital for the purposes of implementing section 5506. By specifying that "the FTE resident cap slots of the hospital that closed no longer exist as part of any other hospital's permanent FTE resident caps" in the August 3, 2010 proposed rule (75 FR 46422), we proposed to emphasize that if slots were permanently transferred to another provider and they continue to exist, section 5506 would not apply. An example of such a situation would be a merger wherein the Medicare provider agreement of one hospital is subsumed into the provider agreement of the surviving provider. In this example, no provider agreement is terminated, and the FTE resident caps also would be subsumed permanently into the provider agreement of the surviving provider. Thus, the purpose of section 5506 is to ensure that slots that are not already part of another hospital's permanent cap are not lost, but rather will be redistributed to qualifying hospitals.

The second commenter's understanding of our proposal regarding acquisitions is correct. We do include

acquisitions in a case in which the new owner terminates the provider agreement of the hospital it purchased in the definition of hospital closure because, in this case, a Medicare provider agreement is terminated, thus releasing the FTE resident cap slots associated with that provider agreement. In addition, we are clarifying that for a hospital that closed due to an acquisition on or after March 23, 2008, and for which CMS has not given those slots to another provider by March 23, 2010, that hospital's slots are governed by section 5506 and CMS' final policies implementing this section.

Comment: One commenter requested that CMS provide additional clarification regarding the definition of a closed hospital. Specifically, the commenter asked: "If the FTEs go permanently to another hospital because of a provision in an affiliation agreement, is the hospital considered closed?" The commenter believed that, in these instances, the hospital is not considered closed, but requested clarification from CMS.

Response: In general, a hospital is not closed unless the hospital's Medicare provider agreement is terminated. With regard to transfers of FTE caps under Medicare GME affiliation agreements, in other instances, we have clarified that hospitals cannot use Medicare GME affiliation agreements to permanently transfer FTE caps from one hospital to another, regardless of whether the hospital transferring the FTE cap slots remains open or closes. As described in the August 1, 2002 final rule (67 FR 50076), effective for Medicare GME affiliation agreements that terminate after October 1, 2002 for any reason, including closure of a participating hospital, FTEs cannot be permanently transferred to another participating hospital even if this circumstance is outlined as a provision in the Medicare GME affiliation agreement. Rather, if a hospital withdraws from the agreement, or if the agreement terminates for any reason, the hospitals participating in the Medicare GME affiliation agreement would revert to their original FTE caps prior to entering into the Medicare GME affiliation agreement. FTE cap transfers occurring under Medicare GME affiliation agreements are temporary and are to be used solely for the purpose of cross-training residents among hospitals that share residency training programs (as described in the regulations at §§ 413.75(b) and 413.79(f).

3. Priority for Hospitals in Certain Areas

Section 1886(h)(4)(H)(vi)(II), as added by section 5506(a) of the Affordable Care Act, specifies that the Secretary shall distribute the FTE cap increases in the following priority order, "with preference given within each category to hospitals that are members of the same affiliated group" (as defined by the Secretary) as the closed hospital:

- First, to hospitals located in the same core-based statistical area (CBSA) as, or in a CBSA contiguous to, the hospital that closed.
- Second, to hospitals located in the same State as the closed hospital.
- Third, to hospitals located in the same region as the hospital that closed.
- Fourth, if the slots have not yet been fully distributed, to qualifying hospitals in accordance with the criteria established under section 5503 ("Distribution of Additional Residency Positions") of the Affordable Care Act.

First, in the August 3, 2010 proposed rule (75 FR 46422), we proposed to use the same pre-reclassification CBSAs that are used for wage index purposes under the IPPS in determining which hospitals are located in the same or contiguous CBSAs as the CBSA in which the hospital that closed was located, without regard to any reclassifications made under the provisions of §§ 412.102, 412.103, 412.230, 412.232, 412.234, and 412.235 of the regulations. Second, we proposed to define "State" in the second priority category to include Puerto Rico and the District of Columbia. Third, we proposed to define "region" in the third priority category as Census Region, consistent with the use of the term elsewhere in the GME regulations. (The term is used for purposes of establishing direct GME PRAs of certain new teaching hospitals at § 413.77(e)(1)(iii).) Fourth, as specified in the fourth priority category, we proposed to employ the criteria for redistribution of residency positions described in section 5503 of the Affordable Care Act, as implemented in the proposed revised regulations at § 413.79(n), should there be any slots not redistributed under the first through third priority categories.

Comment: One commenter supported CMS' proposal to define "region" as census region, consistent with the use of the term elsewhere in the GME regulations. The commenter stated that if CMS elects to use a different definition of "region," the commenter would support defining "region" consistent with the CMS administrative regions (for example, CMS Regions I through X).

Response: We appreciate the commenter's support. We are adopting this proposal as final.

With regard to members of the same Medicare GME affiliated group, we proposed to give priority within each category to hospitals that are members of the same Medicare GME affiliated group as the hospital that closed. A Medicare GME affiliated group, as defined at § 413.75(b), consists of hospitals that enter into a Medicare GME affiliation agreement, also as defined at § 413.75(b), for the purpose of cross-training residents and that, under the terms of the agreement, aggregate and make temporary adjustments to their respective individual FTE resident caps. To provide flexibility to hospitals that have affiliated with the hospital that closed, we proposed to refer to the most recent Medicare GME affiliation agreement of which the closed hospital was a member. Hospitals that were listed as participants of the Medicare GME affiliated group on that most recent Medicare GME affiliation agreement before the closure of the hospital will receive preference in receiving FTE cap increases based on the redistributed slots.

Comment: One commenter noted that, although the commenter understood that CMS is bound by the statute, it suggested that less emphasis be placed on whether a hospital was in an affiliation agreement in the distribution of residency slots resulting from a hospital closure. Alternatively, the commenter suggested that CMS prioritize increasing the caps of applying hospitals that are currently training residents over their caps and, therefore, are training residents that are not funded by Medicare. The commenter did not support the proposal to give preference to an applying hospital based solely on an affiliation that no longer exists with the closed hospital. The commenter posited that if less emphasis was placed on affiliation agreements, there could potentially be more opportunity for new or expanded programs in needed areas such as primary care to emerge as a result of increased caps. The commenter further stated that an applying hospital that had a previous affiliation with a closed hospital could use the increase in its FTE resident cap to train residents in a specialty for which CMS had not identified a need. To prevent this, the commenter suggested that hospitals applying under Ranking Criterion Two should be further ranked based on whether they are also requesting slots for use in specialties for which CMS has identified a need. For example, a hospital that is applying under proposed Ranking Criterion Six to start or expand a primary care program and was also part of an affiliation agreement with the closed hospital should be ranked higher than a hospital that is

applying under proposed Ranking Criterion Six and was not part of the same affiliated group as the closed hospital. However, both hospitals should be ranked higher than a hospital that had been a member of an affiliated group with the closed hospital but is requesting slots to start a non-primary care program (other than general surgery).

Response: While we appreciate the commenter's suggestions, the commenter is correct that we are bound by the statute and cannot consider the suggestions for implementation. The statute does not allow us to ignore a hospital's affiliated status in determining whether the hospital qualifies for a cap increase under section 5506. As such, a hospital that was part of a Medicare GME affiliated group and received slots from the closed hospital would be ranked under Ranking Criterion Two, ahead of a hospital that was not part of the same Medicare GME affiliated group as the closed hospital. We further believe this is appropriate given that a primary consideration under section 5506 is continuity of training programs. Therefore, a hospital that is requesting slots because it seamlessly assumed a program from the closed hospital, even if that program is in a nonprimary care specialty, that hospital would qualify under a higher Ranking Criterion than would another hospital that is requesting the slots to start a new primary care program.

4. Application Process

In the August 3, 2010 proposed rule (75 FR 46422), we proposed to establish an application process for hospitals to apply to CMS to receive an increase in FTE caps based on slots from closed hospitals. Section 5506 of the Affordable Care Act did not specify an effective date or an application deadline for hospitals to request an increase to their caps when a hospital closes. Accordingly, with respect to the first application process to be implemented for section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, and which includes all teaching hospital closures back to March 23, 2008, we proposed that the application deadline would be January 1, 2011. For future teaching hospital closures, we proposed that we would inform the public through an appropriate medium that increases to hospitals' FTE resident caps are available for redistribution due to the closure of a teaching hospital, and the application deadline would be 4 months following the issuance of that notice to the public.

Comment: Commenters noted that CMS proposed an application deadline for distribution of slots under section 5506 of January 1, 2011, for hospitals that closed on or after March 23, 2008, and that for future teaching hospital closures, CMS proposed that hospitals will have 4 months after CMS notifies the public that slots are available to submit an application for those slots. The commenters asked that CMS clarify which deadline will apply to hospitals that close during the comment period between publication of the proposed rule and the final rule. Two commenters encouraged CMS to consider teaching hospitals that closed at any point after publication of the proposed rule to fall into CMS' second category, for which CMS would provide notice and a future application deadline.

Some commenters were concerned that the proposed application deadlines, particularly the first one for January 1, 2011, are too soon. They pointed out that a hospital's decision to take on displaced residents permanently may depend on multiple factors, and receiving ACGME approval for permanent resident positions is also extremely time-consuming. One commenter recognized that hospitals wish for the distribution of these slots to occur as quickly as possible, yet the commenter believed that April 1, 2011, would be a more realistic deadline than January 1, 2011, for the initial set of applications. However, another commenter agreed with the proposed deadline of January 1, 2011.

Response: We agree with the suggestion that any closures after August 3, 2010, the publication date of the proposed rule, should be part of a second hospital closure process for which CMS will send out a separate notice. In addition, we agree that to allow all affected parties sufficient time to gather the documentation necessary to complete and submit an application for slots from a closed hospital, the application date for requesting slots from hospitals that have closed between March 23, 2008 through August 3, 2010, should be extended to April 1, 2011. Therefore, in this final rule, we are establishing the application deadline for receipt of slots from hospitals that closed between March 23, 2008, through August 3, 2010, as April 1, 2011. Hospitals that close at any point after publication of the proposed rule, that is, August 3, 2010, will fall into the second category, for which we will provide separate notice with a future application deadline.

In addition, as the commenters noted, since receiving approval for permanent resident positions is very time consuming, in order to ease the administrative burden on hospitals, similar to the change we made in this final rule under the Demonstrated Likelihood Criterion 1 for section 5503, we are adding to the Demonstrated Likelihood Criteria for section 5506 in this final rule that the hospital may submit documentation demonstrating that it has made a commitment to start a new program or take over a program(s) from the closed hospital. One example of such a commitment would be for the hospital to provide the minutes from the meeting at which the hospital's GME Committee gave approval for the hospital to proceed with the process of applying to the accrediting agency for approval to start a new program.

Comment: One commenter stated that because hospitals interested in applying for resident cap slots under this provision must be put on notice of all slots that will be available through the closed hospital resident slot preservation program, CMS would accomplish this most effectively by publishing in the final rule a list of all hospitals that closed on or after March 23, 2008. In publishing this list, the commenter suggested that CMS also indicate how many cap slots are available from the hospital's 1996 cap versus how many cap slots are available from the section 422 redistribution program. Another commenter also suggested that, for future hospital closures, CMS publish a notice within 60 days from the effective date of the termination of the closed hospital's Medicare provider number.

Response: We agree with the commenter's request and have included at the end of this section a list of teaching hospital closures on or after March 23, 2008 through August 3, 2010, along with their 1996 FTE caps and section 422 caps as applicable. We also appreciate the commenter's suggestion to publish a notice within 60 days from the effective date of the termination of the closed hospital's Medicare provider agreement for future hospital closures. We will publish future closure notices as soon as possible. However, we acknowledge that, in certain cases, due to various circumstances, publication within 60 days may not always be achievable. Therefore, we will not be adopting the requirement to publish a notice within 60 days from the effective date of the termination of the closed hospital's Medicare provider agreement for future hospital closures.

After consideration of the public comments we received, in this final rule, we are establishing the application deadline for receipt of slots from hospitals that closed between March 23,

2008 through August 3, 2010, as April 1, 2011. Hospitals that close at any point after publication of the proposed rule, that is, August 3, 2010, will fall into the second category, for which we will provide separate notice with a future application deadline.

5. Ranking Criteria

Unlike the application process for FTE cap increases under section 1886(h)(8) of the Act as added by section 5503 of the Affordable Care Act, we did not propose to establish a "point" system to distinguish between hospitals within each of the first three priority categories. Rather, within each of the three first statutory priority categories in section XXI.E.3. of this preamble (that is, same or contiguous CBSAs, same State, and same Region), in the August 3, 2010 proposed rule (75 FR 46422), we proposed to rank categories in which we would assign slots *first* to hospitals that fall within the first ranking category *before* assigning slots to those hospitals that fall within the second ranking category, and would assign slots to those hospitals that fall within the second ranking category *before* assigning slots to hospitals in the third ranking category, and so forth. We did not propose to use these ranking categories within the fourth priority category because, under that fourth priority category, the Secretary would use the process established under section 5503 for section 1886(h)(8) of the Act. In order to maintain stability in existing GME programs, these proposed ranking categories generally give preference to applying hospitals that demonstrate a commitment to continue training residents in the same programs that the closed hospital operated, or that had a training relationship with the closed hospital (such as a Medicare GME affiliation agreement).

- *Ranking Criterion One. The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, same program director, and same (or many of the same) teaching staff).* We proposed this ranking criterion because we understand that there are situations where, when a hospital is acquired and its provider agreement is terminated and a new provider agreement is established in the place of the old one, the new formed "acquiring" hospital continues to operate the GME programs seamlessly and in the same manner as under the previous provider agreement. If this situation occurs, we believe the new hospital with the new provider agreement is demonstrating a strong commitment to not only maintain the GME programs in the community for the long term (that is, continuity), but to also allow the residents that were at the hospital when the change in provider agreement occurred to continue to train there, such that no residents are displaced and no training is interrupted.

Alternatively, it is possible that perhaps a year or more prior to a hospital's closure, the hospital closed some or all of its residency programs, and another hospital assumed an entire program (or programs) at the time of the residency program's closure, and the applying hospital has continued to operate that program seamlessly, as it had been operated at the hospital that ultimately closed. Because the applying hospital has also demonstrated a strong commitment to continuity of the residency program(s) in the community by assuming the program(s) even prior to the other hospital's closure, we proposed that the applying hospital would be categorized in Ranking Criterion One.

- *Ranking Criterion Two. The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement.* We proposed this ranking criterion because section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, directs the Secretary to give preference to hospitals that are members of the same affiliated group as the hospital that closed. We believe that, generally, if the applying hospital was affiliated to *receive* slots from the hospital that closed, then the applying hospital was relying on that number of FTE resident slots that it received in order to maintain its fair share of the cross-training of the residents in the jointly operated programs. In the absence of those slots received from the closed hospital, the applying hospital may not be able to continue training that number of FTE residents, and those same residents would not only be displaced from the closed hospital, but might essentially become "displaced" from the affiliated hospitals in which they were used to doing a portion of their training. Accordingly, we proposed this ranking criterion to allow hospitals that were affiliated with the closed hospitals to at least maintain their fair share of the training of the residents in the programs that they had jointly operated with the closed hospital. We note that we proposed this ranking criterion regarding affiliated hospitals as second, after the first ranking criterion regarding applying hospitals that assume an entire program or programs from the closed hospital because, even though section 5506 of the Affordable Care Act directs the Secretary to give preference to members of the same affiliated group, we believe that a hospital that assumes the responsibility for an entire program or programs demonstrates a commitment to maintain the programs to an even greater degree than does a hospital that was affiliated with the hospital that closed and may only be maintaining a portion of the residency program or programs.

- *Ranking Criterion Three. The applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training (that is, the applying hospital is permanently expanding its own existing programs).* Similar to Ranking Criterion Two, hospitals fitting into Ranking Criterion Three also demonstrate a commitment to protect residents displaced by a hospital's closure, and to ensure that there is a degree of continuity in the community with respect to the particular training program or programs that the closed hospital operated. However, because an applying hospital fitting into this category was not part of the same Medicare GME affiliated group as the closed hospital, we proposed that this category would be ranked as third, below Ranking Criterion Two which relates to hospitals that were members of the same affiliated group as the closed hospital.

We proposed that the next five proposed ranking criteria would apply in the instance where there are still slots available from the closed hospital after distributing slots to hospitals falling within the first three ranking criteria. Thus, hospitals fitting into proposed Ranking Criteria Four through Eight would not fit into proposed Ranking Criteria One, Two, or Three, but they can demonstrate that they will use the slots in a manner that is consistent with

current Medicare policy goals, as indicated in section 5503 of the Affordable Care Act, such as using the slots for a geriatrics or for other primary care residency programs, or for a general surgery residency program.

- *Ranking Criterion Four. The applying hospital does not fit into Ranking Criteria One, Two, or Three, and will use additional slots to establish a new or expand an existing geriatrics residency program.*
- *Ranking Criterion Five. The applying hospital does not fit into Ranking Criteria One, Two, or Three, is located in a Primary Care HPSA, and will use all the additional slots to establish a new or expand an existing primary care residency program.*
- *Ranking Criterion Six.* The applying hospital does not fit into Ranking Criteria One, Two, or Three, and will use all the additional slots to establish a new or expand an existing primary care residency program.
- *Ranking Criterion Seven.* The applying hospital does not fit into Ranking Criteria One, Two, or Three, and will use all the additional slots to establish a new or expand an existing general surgery residency program.
- *Ranking Criterion Eight.* The applying hospital does not fit into Ranking Criteria One through Seven.

Comments on Ranking Criterion One

Comment: Several commenters generally supported CMS' proposal to prioritize the distribution of resident slots to applying hospitals that assume and seamlessly continue to operate a closed hospital's entire program. However, the commenters also noted that additional efforts must be made in order to meet the nationwide need for residency slots.

Response: We appreciate the commenters' support for the proposal to prioritize the distribution of resident slots to applying hospitals that assume and seamlessly continue to operate a closed hospital's entire program. Any additional efforts to address the commenters' stated need for additional residency slots would need to be addressed by Congress as a legislative change affecting hospitals' existing caps.

Comment: One commenter stated that, although it was appreciative of CMS' attempts to create a mechanism for the redistribution of residency slots from closed hospitals, the proposed priority ranking criteria may be too restrictive for many teaching hospitals to achieve. The commenter asked CMS to consider the ability of current GME programs that are able to meet critical primary care needs as a high priority during the application process.

Response: We believe we have developed a system to distribute slots from closed hospitals that will be administratively achievable and that will primarily promote the continuity of existing programs. We also recognize the importance of training primary care physicians, and we have included Ranking Criteria which reflect this accordingly.

Comment: One commenter observed that CMS included two types of scenarios in which an applicant hospital would be categorized within Ranking Criterion One: a situation in which a closed teaching hospital is acquired by another hospital that continues to train all residents from the program on the same site; and a situation in which a hospital closes some or all of its residency programs a year or more prior to the hospital's closure, and those programs are assumed by another hospital at a different site. The commenter agreed that hospitals assuming residency programs under both of these scenarios should be entitled to the preferential treatment of Ranking Criterion One, but believed that CMS inadvertently omitted a third example of when this first ranking criterion would apply. That is, the commenter believed that a hospital should also be eligible for Ranking Criterion One if it is located on a site that is different from the closed hospital, and assumes an entire program at the time the hospital closes (not a year or more prior to the hospital's closure). The commenter requested that CMS clarify that this third scenario would fit into Ranking Criterion One as well.

Response: The commenter raises a good point and is correct that we did not intend to exclude the third scenario from qualifying under Ranking Criterion One which would involve a hospital that is located on a different site than the closed hospital, and that hospital assumes an entire program simultaneous to the closure of the other hospital, and not a year or more prior to the hospital's closure. We are clarifying in this final rule that a hospital is eligible for Ranking Criterion One if it is located on a site that is different from the closed hospital, and assumes an entire program at the time the hospital closes (not a year or more prior to the hospital's closure). In fact, we are adding a fourth scenario in this final rule that could fit into Ranking Criterion One—that is, when one hospital acquires another hospital, retires the provider agreement of the acquired hospital, and creates a multi-campus hospital, but otherwise, the second campus continues to operate as before. In that case, the acquiring hospital may qualify under Ranking Criterion One. In addition, we are clarifying and refining the timeframe we had in mind when describing the scenario where one hospital assumes a program "a year or more" prior to the closure of another hospital (75 FR 46423). We did not mean that a hospital that took over a program 20 years before the closure of a hospital would qualify under Ranking Criterion One. Rather, we intended to convey a relatively short timeframe prior to the hospital's closure in which another hospital assumed a program. For purposes of this final rule, we are clarifying that in order to qualify under Ranking Criterion One in the instance where a hospital assumed a program(s) from a hospital that closed prior to the hospital's closure, the hospital must have assumed the program(s) in its entirety no more than 5 years prior to the date of the hospital's closure.

Comment: One commenter suggested that CMS reorder Ranking Criteria One and Two and give precedence to applicant hospitals that have an affiliation agreement with the closing hospital. The commenter also suggested that if the applicant hospital is also a member of the affiliated group and a corporate affiliate (subsidiary, parent or sister corporation) of the closing hospital, it should be given the highest priority within Ranking Criterion One. The commenter believed that Congress intended to allow hospitals that are part of an affiliated group, to keep FTEs that would otherwise be lost because of the closure of a hospital within the affiliated group. The commenter suggested that if CMS wishes to protect programs that would continue to run after a hospital "closes" because it is acquired (and its provider number terminated), CMS could specify this item as the second ranking criterion as long as it specifies that this scenario is a result of an acquisition. The commenter further noted that the requirement to operate the program exactly as it was operated before may be counterproductive. The commenter indicated that it may, for example, cause the acquiring hospital to avoid replacing faculty members that were not performing well or making other improvements.

Response: We acknowledge that Congress desired to give preference to hospitals that are members of the same Medicare GME affiliated group as the closed hospital when distributing the slots from the closed hospital, as stated in section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act. However, we are

not convinced that being a member of the same Medicare GME affiliated group alone, or being a corporate affiliate of the closed hospital, warrants a greater degree of preference than hospitals that assume an entire program or programs from the closed hospital. As we explained in the August 3, 2010 proposed rule (75 FR 46423), "We note that we are proposing this ranking criterion regarding affiliated hospitals as second, after the first ranking criterion regarding applying hospitals that assume an entire program or programs from the closed hospital because, even though section 5506 of the Affordable Care Act directs the Secretary to give preference to members of the same affiliated group, we believe that a hospital that assumes the responsibility for an entire program or programs demonstrates a commitment to maintain the programs to an even greater degree than does a hospital that was affiliated with the hospital that closed and may only be maintaining a portion of the residency program or programs."

Furthermore, the commenter need not be concerned that hospitals that would fit into Ranking Criterion Two would be at a disadvantage and deprived of their fair share of slots to hospitals that would fit under Ranking Criterion One. In fact, Ranking Criteria One and Two are *not* competing with each other, and hospitals fitting into each category would get their "fair" share of slots. For example, assume a hospital with an FTE resident cap of 100 closes. Hospital A assumes the entire programs in which 80 FTE residents were training when the hospital closed. Hospital B had been receiving 20 FTE slots from the closed hospital under the terms of a Medicare GME affiliation agreement. Hospital A applies for 80 slots under Ranking Criterion One and, all other things being equal, is awarded 80 slots. Hospital A could apply for more than 80 slots, *but it could only receive consideration under Ranking Criterion One for a maximum of 80 slots.* Therefore, 20 slots would remain for Hospital B to apply for and receive under Ranking Criterion Two. Accordingly, we do not believe it is necessary to reorder Ranking Criteria One and Two.

Comment: Some commenters asked for clarification regarding what CMS meant by a hospital assuming an "entire" program. One commenter urged CMS to be flexible with applicants for Ranking Criterion One and clarify that a hospital that takes on "substantially all of the residents training in a particular program at the closed hospital prior to the hospital's closure or at the time of the hospital's closure" would be deemed to have assumed an "entire" program. The commenters pointed out that there may be reasons beyond the control of an applying hospital as to why it may not be able to assume *all* of the residents in a program from the hospital that closed, unfairly placing the applying hospital in a lower ranking category than Ranking Criterion One. For example, one or more residents might choose not to train at the applying hospital with the rest of their program colleagues, but instead may choose to complete their training elsewhere.

Additionally, the commenters asked CMS to define an "entire program" to include only FTE residents training in the closed hospital at the time of the hospital's closure. For example, if a particular program at a closed hospital consists of 50 residents, but 20 were training at another hospital at the time of the closure, a hospital that agrees to assume the remaining 30 residents who were all training at the closed hospital should qualify under "Ranking Criterion One," even though the hospital did not assume the program's full complement of 50 residents.

Response: We agree with the commenters that flexibility in the definition of "entire" program is appropriate because there could be reasons beyond the control of the applying hospital why it is unable to assume all of the residents from the closed hospital. The commenters recommended that a hospital that takes on "substantially all of the residents training in a particular program at the closed hospital prior to the hospital's closure or at the time of the hospital's closure" would be deemed to have assumed an "entire" program. We agree with this concept, and for purposes of section 5506, we are stating that a hospital that takes on 90 percent of the residents training in a particular program at the closed hospital within 5 years prior to the hospital's closure or at the time of the hospital's closure would be deemed to have assumed an "entire" program. We note that assuming the "entire" program, even if it is 90 percent or more of the residents, implies no limitation based on the closed hospital's FTE resident cap. For example, if a closed hospital is only training residents in an internal medicine program, its FTE resident cap is 10, and it was training 15 FTEs, then assumption of the "entire" program does not mean 10 FTEs, it means at least 90 percent of 15, i.e., 13.5 FTEs. The applying hospital may request up to 13.5 FTEs under Ranking Criterion One.

In the example that the commenters provided regarding a particular program at a closed hospital that consists of 50 residents, but 20 were training at another hospital at the time of the closure, we agree that a hospital that assumes the remaining 30 residents who were all training at the closed hospital should qualify under "Ranking Criterion One," even though the hospital did not assume the program's full complement of 50 residents. This policy with regard to what constitutes a "closed program" is consistent with our current policy and definition of "closure of a hospital residency program" at § 413.79(h)(1)(ii), which means "the hospital ceases to offer training for residents in a particular approved medical residency training program." This definition recognizes that hospitals often co-sponsor accredited programs, so that while one of the hospitals may cease to provide training in that accredited program, the program and rotations still continue to exist at the other hospitals that co-sponsor and train residents in that same accredited program. Furthermore, in light of the clarified definition of "entire" program above, using this example, an applying hospital need only assume 90 percent of the 30 FTE residents, or 27 FTE residents, in this particular program from the closing hospital. However, we note that if a hospital is only assuming 90 percent of the residents in the program, then it may only apply to receive 90 percent of the slots in the program under Ranking Criterion One. If the applying hospital plans to further expand the program and can meet the demonstrated likelihood requirement for doing so, it may possibly qualify for those additional slots under Ranking Criterion Four through Seven (but not under Ranking Criterion Three because Ranking Criterion Three is for instances where less than an "entire" program is assumed).

Comment: One commenter acknowledged CMS' intent to promote continuity and supported this requirement for hospitals that close on a going forward basis. However, the commenter did not believe that the "seamless" operation requirement under Ranking Criterion One should apply to hospitals that apply for resident cap slots from hospitals that closed between March 23, 2008, and the date of publication of the final rule. Another commenter understood "seamless" to mean that there cannot have been a point at which the assumption of the program was interrupted. The commenter believed this requirement is "wholly unfair" to hospitals that assumed programs from hospitals that closed prior to the publication of the proposed or final rules. The first commenter believed that while these

hospitals may have been willing to provide a service to the community by continuing the entire residency program from the closed hospital, they were not previously on notice that they would have to do so "seamlessly." The second commenter asserted that this proposed requirement "drastically minimizes the importance to these hospitals of Medicare GME funding." The commenters believed that it is unrealistic and unfair for CMS to expect a hospital to have applied for ACGME approval to train an entire program on a permanent basis without "any clear indication that Medicare funding would be continuing." For these reasons, the commenters urged CMS to adopt the "seamless" requirement for Ranking Criterion One on a prospective basis only.

Response: As the commenters acknowledge, our intent in implementing section 5506 is to promote continuity, and, therefore, our intent is that "seamless" assumption of a program from a closed hospital *does* mean that there cannot have been a point at which the assumption of the program was interrupted. The commenters are describing situations where hospitals have closed in the past one or two years, and while the programs from those closed hospitals may have been transferred "seamlessly" to the applying hospitals 1 or 2 years ago, the applying hospitals have allowed those programs to phase out, as the residents that had originally trained at the closed hospital have graduated. We understand that Medicare GME funding is extremely important to teaching hospitals, and the absence of it may be a strong factor in an applying hospital's decision to allow a transferred program to phase out. Further, we have never required other teaching hospitals to absorb additional residents on a temporary or permanent basis. While we do not negatively regard a hospital that did not seamlessly assume a program or programs from hospitals that have already closed, we also do not see the need to reward these same hospitals by ranking them under Ranking Criterion One, now that the prospect of additional Medicare GME funding may be available to them and they are willing to "revive" phased-out programs. Rather, we believe these hospitals could apply for slots under section 5506 and may, in fact, receive them, but they would be ranked under criteria below Ranking Criterion One, as appropriate. Accordingly, we do not believe it is necessary to adopt the "seamless" requirement under Ranking Criterion One on a prospective basis.

Comment: One commenter noted that CMS proposed that, to qualify under Ranking Criterion One, an applying hospital must "continu[e] to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, same program director, and same (or many of the same) teaching staff)." While the commenter understood that such continuity may be the likely outcome of moving the entire program to a new hospital, the commenter believed that decisions about who the program director and teaching staff should be are better left to the "leaders of academic medicine" to decide, and "should not be dictated by CMS or used as a litmus test for whether a hospital has "assumed" an entire program." The commenter expressed particular concern about these requirements in situations in which an already-existing teaching hospital takes over the entire program. The commenter pointed out that, unlike nonteaching hospitals just beginning to train residents, such teaching hospitals may not need to hire additional faculty or program directors, but instead, may simply absorb the entire program into one of its own, already-established residency training programs (perhaps, for example, to avoid having two identical programs at the same hospital). The commenter believed that the adopting hospital should not be forced to hire these individuals from the closed hospital to meet "Ranking Criterion One." The commenter argued that such staffing decisions should be in the hands of the academic medical leaders who assume responsibility for the program.

Response: In the proposed rule, we defined "assuming an entire program" as maintaining the same residents, staff, and program director as the original program because that is consistent with our policy, as clarified in the FY 2010 IPPS/LTCH PPS final rule, regarding the definition of assuming an existing program (as distinguished from starting a brand new program). However, we believe that, in this case, Congress was concerned with preservation of FTE cap slots, and maintaining continuity for the residents. Therefore, we agree with the commenter that a hospital may fit into Ranking Criterion One without taking in the same staff and program director of the closed hospital, and instead it may be determined to have assumed an entire program if it trains all of the residents from the closed hospital's program.

Comment: One commenter asked CMS to use its authority to give slots from hospitals that have closed to be used for replacement of positions of family medicine programs that have closed. The commenter acknowledged that hospitals frequently close family medicine training programs and use its current slots to promote production of more lucrative specialties. The commenter urged the Secretary to utilize the authority under Ranking Criterion One to distribute slots from the closed hospital to those hospitals in the same core-based statistical area (CBSA) that have continued to operate a family medicine residency program that was closed by another hospital with the same program director and the same residents with the family medicine residency program. The commenter requested parallel provisions under Ranking Criteria Two and Three.

Response: Ranking Criterion One addresses the commenter's request to provide preference to hospitals in the same CBSA that assume an entire family medicine program that was previously operated by a hospital that closed. Although Ranking Criterion One does not specify any one specialty in particular; it does provide preference to a hospital that assumed an entire program in any specialty (including family medicine) that closed as a result of a hospital closure. It is important to note that in the event a program closes for reasons other than hospital closure (assuming the hospital does not subsequently close shortly thereafter as well), these slots will not be available for redistribution under section 5506.

Comments on Ranking Criterion Two

Comment: Some commenters believed that CMS proposed to interpret too strictly the requirement for giving preference to hospitals that are members of the same affiliated group as the hospital that closed. The commenters noted that section 5506 merely states that CMS shall give preference within each geographic category "to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital." The commenter further noted that CMS proposed that in order to receive preference, the applying hospital must have *received* slots from the closed hospital under the terms of the affiliation agreement. The commenters asserted that Congress never limited this priority to only hospitals that received slots from the closed hospital under the affiliation agreement. Rather, the commenters believed that having a relationship with the closed hospital "in the context of a GME affiliated group" should be sufficient to qualify for preference.

Response: As we have explained in the proposed rule and as the commenters acknowledge, we believe the intent of section 5506 is to promote

continuity and limit disruption in residency training. In that light, we believe it is logical to give preference to a hospital that received slots under the terms of the Medicare GME affiliation agreement so that the hospital could continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement, avoiding the displacement of even more residents. We do not see why a hospital that loaned slots to the closed hospital under the terms of the Medicare GME affiliation agreement warrants special consideration if it wants more slots, simply because it was a member of the same affiliated group. We further disagree with the commenter's argument that having a relationship with the closed hospital "in the context of a GME affiliated group" should be sufficient to qualify for preference. We note that under the rules of the "shared rotational arrangement" (as defined at § 413.75(b)) which is a requirement for all members within the same Medicare GME affiliated group, it is possible for a hospital in the same Medicare GME affiliated group as the closed hospital not to have any rotating relationship with the closed hospital—it may have a training relationship with other hospitals in the group which in turn, had the training relationship with the closed hospital. We see no reason to grant this hospital, which had no direct training relationship with the closed hospital, preference under Ranking Criterion Two, simply because it was a member of the same Medicare GME affiliated group as the closed hospital. Therefore, we are not adopting the commenter's recommendation, and are only giving preference to hospitals that *received* slots from the closed hospital under the terms of the Medicare GME affiliation agreement, so that the hospital could continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. We also note that should the hospital that received slots from the closed hospital, or should the hospital that lent slots to the closed hospital, desire to assume *additional* programs or parts of programs from the closed hospital, they may qualify for slots for those respective programs under Ranking Criteria One, Three, or others, as appropriate.

Comment: One commenter stated that limiting preference to hospitals that received slots under the most recent affiliation agreement would deny some hospitals the opportunity to regain slots unfairly lost due to prior affiliation agreements. Therefore, the commenter asked CMS to expand preference for the redistributed slots to hospitals that were part of the same affiliated group at any point within 5 years prior to the statutory cut off of March 23, 2008. The commenter also asked CMS to ensure that any hospitals operating under the same provider number as a member of the affiliated group during that time period are eligible for the slots.

Response: In determining which hospitals qualify under Ranking Criterion Two regarding being in the same Medicare GME affiliated group as the hospital that closes, we believe, as the proposed Ranking Criterion Two specifies, that the hospital or hospitals that were most recently affiliated with and received slots from the closed hospital would have the most immediate need for those slots. Hospitals that have not been affiliated with the closed hospital for a year or more would not likely be as reliant on the slots from the closed hospital, nor would they be affected quite so significantly by the sudden closure of the hospital. Nevertheless, we acknowledge that it is possible that limiting Ranking Criterion Two to only hospitals that had been affiliated with the closed hospital on the most recent Medicare GME affiliation prior to the hospital's closure in some instances might be too restrictive, and could deny hospitals that were affiliated with the closed hospital in prior years some share of the slots upon which they are still reliant. We believe the commenter's recommendation that CMS expand preference for the redistributed slots to hospitals that were part of the same affiliated group at any point within 5 years prior to the statutory cut-off of March 23, 2008, has merit. We believe an administratively feasible approach would be one in which, as a first step, we would refer to the Medicare GME affiliation agreement of which the closed hospital was a member most recently prior to its closure. Those hospitals in that most recent Medicare GME affiliation agreement that received slots from the closed hospital would get first preference under Ranking Criterion Two. However, in the case where the most recent Medicare GME affiliation agreement of which the closed hospital is a member before it closes is with a hospital that also has closed or is closing, we would then refer to a previous affiliation agreement, or agreements, but not to Medicare GME affiliation agreements that were entered into more than 5 years prior to the hospital's closure. Preference would then be given to an applying hospital that was listed as a participant in the next most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, but would be limited to affiliations entered into in the past 5 years, and that the applying hospital received slots from the closed hospital under the terms of that affiliation agreement. We are modifying Ranking Criterion Two to read as follows:

- *Ranking Criterion Two. The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. If the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed was with a hospital that itself has closed or is closing, preference would be given to an applying hospital that was listed as a participant in the next most recent Medicare GME affiliation agreement (but not one which was entered into more than 5 years prior to the hospital's closure) of which the first closed hospital was a member before the hospital closed, and that applying hospital received slots from the closed hospital under the terms of that affiliation agreement.*

Finally, to address the commenter's request, we are confirming that a hospital that undergoes a name change but whose provider number and agreement do not change while it is a member of the affiliated group during the 5 years prior to the closure, could be eligible for receipt of slots from the closed hospital.

Comment: One commenter requested that CMS confirm that the Ranking Criterion Two preference would be given only for the total number of resident slots that the applying hospital *actually received* from the closed hospital pursuant to the former affiliation agreement between them.

Response: In the August 3, 2010 proposed rule (75 FR 46423), we describe that Ranking Criterion Two gives preference to hospitals that are "listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital *received* slots from the hospital that

closed, and the applying hospital will use the additional slots to continue training at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement." Therefore, under Ranking Criterion Two, a hospital may request as many slots as it received under its most recent affiliation agreement. This would be the number of FTE residents that were transferred from the closed hospital in the most recent affiliation agreement (or as amended by June 30 of that academic year, if applicable). Therefore, under Ranking Criterion 2, preference would only be given for the total number of residents slots that the applying hospital actually received from the closed hospital.

Comment: One commenter suggested that CMS reorder Ranking Criteria One and Two and give precedence to applicant hospitals that have an affiliation agreement with the closing hospital. The commenter also suggested that if the applicant hospital is also a member of the affiliated group and a corporate affiliate (subsidiary, parent or sister corporation) of the closing hospital, it should be given the highest priority within Ranking Criterion One. The commenter believed that Congress intended to allow hospitals that are part of an affiliated group to keep FTEs that would otherwise be lost because of the closure of a hospital within the affiliated group. The commenter suggested that if CMS wishes to protect programs that would continue to run after a hospital "closes" because it is acquired (and its provider number terminated), CMS could specify this item as the second ranking criterion as long as it specifies that this scenario is a result of an acquisition. The commenter further noted that the requirement to operate the program exactly as it was operated before may be counterproductive. The commenter stated that it may, for example, cause the acquiring hospital to avoid replacing faculty members that were not performing well or making other improvements.

Response: We disagree with the commenter's suggestion that we reorder the Ranking Criteria to give first preference to hospitals that were members of the same affiliated group as the closed hospital, and rather, we assert that the primary principle for a section 5506 is continuity of existing training. Therefore, we are finalizing our proposal to give priority to a hospital that will continue to operate the existing program, either at the original site or at another hospital.

Comment: One commenter noted that while under CMS' ranking criteria, hospitals are awarded slots from a closed hospital for particular uses (for example, to establish a new or expand an existing geriatrics residency program), CMS did not specify the period of time during which these slots would be restricted to these specific uses. The commenter believed that CMS should place a 5-year limit on hospitals' obligation to use the slots for the purpose for which the hospital is awarded the slots, as this amount of time is consistent with the amount of time with the restrictions Congress imposed. Furthermore, the commenter stated that while it is unlikely that hospitals would change their programs after only five years, they should be permitted the flexibility to adapt their programs as their educational needs or the patient care needs of the community change.

Several commenters also disagreed with the proposal that any slots awarded through the closed hospital redistribution program may not be used as part of the aggregate cap in a Medicare GME affiliation agreement, and encouraged CMS to permit hospitals to use these slots as part of a GME affiliation agreement. One commenter suggested that perhaps CMS could permit hospitals to use these slots as part of a GME affiliation agreement after 5 years.

Response: As we have stated in this final rule, each application by a hospital must be program specific. That is, the hospital must complete a separate CMS Evaluation Form for each program and demonstrate the likelihood of filling the slots in each program. However, increases in hospital's FTE resident caps under section 5506 for direct GME and IME, once granted to a hospital, are no longer program specific. Rather, the caps are applied to any residents the hospital trains in excess of its otherwise applicable FTE cap(s) (which could include the hospital's 1996 caps, subject to permanent adjustments for new programs or reductions under section 1886(h)(4)(H) of the Act).

We also note that hospitals must sign an attestation as part of the hospital's application for the overall increase to the cap under section 5506 to certify that the information claimed in the application is true at the time of the application. Thus, if a hospital claims on one of its CMS Evaluation Forms that the hospital is applying for the increase because it plans to use the FTEs because it is training residents from a program or a hospital that closed, and the applicant hospital no longer qualifies for a temporary adjustment to its cap, at least at the time of the application, the hospital intends to use at least that part of its section 5506 cap for this stated purposes (that is, the purposes documented in the hospital's application).

We agree with the commenters that slots awarded under section 5506 should be permitted for use as part of the aggregate cap in a Medicare GME affiliation agreement. As we stated in response to a similar comment received regarding section 5503 slots, we understand that training needs can change over time, and there may be a need to cross-train residents in different hospital settings. In addition, since slots received under section 5506 are to be paid with the same direct GME PRA and IME multiplier as a hospital's other residents (unlike slots received under section 422 of the MMA which are paid at different payment rates), it would not present an administrative burden to include section 5506 slots in Medicare GME affiliation agreements. The commenter suggested that we allow the slots awarded under section 5506 to be used in Medicare GME affiliation agreements after 5 years. We believe 5 years is a reasonable timeframe for hospitals to use the slots they received for the purpose for which they applied for those slots. After a 5-year period, a hospital that received slots under section 5506 may use those slots as part of its FTE residents caps in a Medicare GME affiliation agreement. The 5 years will begin prospectively from the date that the slots were made permanent at each respective hospital.

Comments on Ranking Criterion Three

Comment: Commenters requested that, as under Ranking Criterion One, CMS not require that a hospital must have requested a permanent expansion of their residency program from the accrediting body prior to the conclusion of the training of a displaced resident in order to qualify for Ranking Criterion Three, or that CMS not require that the applying hospital must have permanently expanded its program immediately following the completion of the displaced residents' training. One commenter requested that here too, CMS should apply any similar "seamless" approach on a prospective basis only.

Response: As we stated in response to the similar previous comment regarding Ranking Criterion One, our intent in implementing section 5506 is to promote continuity. Therefore, in order to qualify under Ranking Criterion Three, the applying hospital must have permanently expanded its program immediately following the completion of the displaced residents' training. If there was an interruption in the

expansion of the program, perhaps the hospital could apply for slots under section 5506, and may in fact receive them, but the hospital would be ranked under a criterion below Ranking Criterion Three, as appropriate. Accordingly, we do not believe it is necessary to adopt the "seamless" requirement under Ranking Criterion Three on a prospective basis.

Comment: Some commenters requested that Ranking Criterion Three should apply to a hospital that took in displaced residents, regardless of whether the applying hospital actually qualified for and received a temporary cap adjustment for the displaced resident(s). One commenter also observed that, in the proposed rule, CMS did not specify the means by which a hospital would need to demonstrate that it took in displaced residents (that is, CMS did not specify that only a hospital that actually received a temporary cap adjustment for the displaced resident(s) could qualify under Ranking Criterion Three). The commenter argued that, regardless of whether the applying hospital needed or received a temporary cap adjustment, the applying hospital "performed no less of a service to the community and to the resident's education as a hospital that required temporary cap slots to be paid for the residents' training time." The commenter requested that CMS be flexible in the ways it would allow a hospital to demonstrate that it took in displaced residents, including through ACGME documents indicating approval for temporary training.

Response: We disagree with the commenter's argument that regardless of whether the applying hospital needed or received a temporary cap adjustment, the applying hospital "performed no less of a service to the community and to the resident's education as a hospital that required temporary cap slots to be paid for the residents' training time." Moreover, we believe that whether the applying hospital actually needs a temporary cap adjustment is indeed relevant because a hospital that has sufficient room under its FTE resident cap to train displaced residents would not need to apply for additional slots under section 5506 in order to continue training those residents. Therefore, such a hospital would only need to apply under Ranking Criterion Three if it is currently training residents in excess of its FTE resident cap. However, it is possible that a hospital may not have received a temporary cap adjustment because at the time of hospital closure, there simply were not enough available caps available to cover each of the displaced residents. In such a case, the hospital could demonstrate a need for additional caps to continue training the displaced residents in the absence of a temporary cap adjustment. With regard to the commenter's second point, we will accept ACGME documents that indicate approval for temporary training as legitimate documentation to demonstrate that a hospital took in displaced residents.

Comment: One commenter suggested that, similar to Ranking Criterion One, CMS limit the number of residency slots that could be awarded to an applying hospital under Ranking Criterion Three to the actual number of individual residents that the applying hospital took in and trained through the completion of their residencies.

Response: We agree with the commenter and will limit the number of residency slots that will be awarded to an applying hospital under Ranking Criterion Three to the actual number of individual displaced FTE residents that the applying hospital took in and trained through the completion of their residencies.

Comments on Ranking Criteria Four Through Seven

Comment: One commenter acknowledged that CMS devised the Ranking Criteria Four through Eight consistent with the spirit of the preferred specialties under section 5503, but did not believe it is appropriate for CMS to make judgments regarding the appropriateness of one type of program versus another "absent a clear directive within the ACA." The commenter believed all primary care programs and general surgery were deemed equally important within section 5503, and therefore, geriatrics should not be favored, nor should primary care be ranked above general surgery. The commenter recommended that Ranking Criteria Four through Eight be simplified and collapsed into the following three criteria:

- Recommended Ranking Criterion Four: Applying hospital does not meet ranking criterion 1, 2, or 3, is located in a HPSA, and is seeking to establish or expand a primary care or general surgery residency program.
- Recommended Ranking Criterion Five: Applying hospital does not meet ranking criterion 1, 2, or 3, is not located in a HPSA, and is seeking to establish or expand a primary care or general surgery residency program.
- Recommended Ranking Criterion Six: Applying hospital seeks the slots for purposes that do not fit into any of the above ranking criteria.

Another commenter suggested that Ranking Criteria Four, Five, and Six should be reorganized to place a higher priority on primary care rather than geriatrics. The commenter believed that, based on available data, there is a greater need for primary care than for geriatrics in communities that have large Medicare and Medicaid populations. The commenter also noted that Ranking Criterion 4 does not require the applying hospital to use every additional slot to establish a new or expand an existing geriatrics residency program, but proposed Criteria 5 and 6 would require the applying hospital to use all the additional slots for primary care residency programs. The commenter believed that this distinction suggests that CMS recognizes the need for additional primary care residency slots and therefore should support the reprioritization of Ranking Criteria Four, Five, and Six.

This same commenter was supportive of Ranking Criteria Seven and Eight. The commenter also provided some additional criteria that could be used in this process. The suggested additional criteria include: (1) The percentage by which the applying hospital is operating above its Medicare-funded GME and IME FTE caps; (2) whether the applying hospital qualifies for DSH payments; and (3) the ratio of unfunded residents to Medicare census. The commenter also suggested that, within each criterion, preference should be given to hospitals that were deemed qualified to receive additional FTE slots pursuant to section 422 of the MMA, but that did not receive any additional slots through that process.

Response: We agree with the first commenter's suggestions regarding simplifying and collapsing Ranking Criteria Four, Five, and Six. However, the commenter did not specify that the applying hospital will use "all" the additional slots toward primary care or general surgery, and we are adding "all" to our final ranking criteria as follows:

- Ranking Criterion Five: Applying hospital does not meet ranking criterion 1, 2, or 3, is located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program.
- Ranking Criterion Six: Applying hospital does not meet ranking criterion 1, 2, or 3, is not located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program.
- Ranking Criterion Seven: Applying hospital seeks the slots for purposes that do not fit into any of the above ranking criteria.

We also agree that general surgery should not be given priority over other

primary care specialties. However, we do believe that geriatrics should be favored within the section 5506 ranking criteria, as the field of geriatrics specifically serves the beneficiaries of the Medicare program. Therefore, we are retaining our original Ranking Criteria four, and we are adopting the Ranking Criteria Five, Six, and Seven stated above.

With regard to the comment that Ranking Criterion Four does not require all of the slots awarded to be used toward geriatrics, unlike the final Ranking Criteria Five, Six, and Seven that do require all of the slots awarded to be used toward each criterion's respective specialty, we are specifically not requiring all of the slots awarded under Ranking Criteria Four to be used for geriatrics because a hospital may not necessarily need so many slots for geriatrics fellowships, which typically are not large programs. Therefore, because applications under section 5506 are program-specific, we believe that a hospital that is applying for slots for use in a geriatrics program should not be precluded from also applying for slots for other programs (although the requests for those other programs, even other primary care or surgery programs, would fall under Ranking Criterion Seven). We are not adopting the second commenter's remaining suggestions for additional criteria, as they represent goals and policies that do not necessarily align with the policy goal of section 5506, which is continuity and preservation of existing GME infrastructure in an area.

Comment: One commenter requested that a ranking criterion preference should be given to hospitals training primary care residents, particularly family medicine residents, with "principal preference" given to hospitals that have been operating a family medicine program as of the enactment of the Affordable Care Act, and have been doing so without Medicare GME reimbursement, and do not have an FTE cap established. The commenter believed that hospitals that are supporting programs that, by application of CMS regulations, have not qualified for payment "would be greatly strengthened" by the receipt of slots from teaching hospitals that closed. The commenter believed that CMS should establish a first priority Ranking Criterion for such hospitals, across the first three of the priority order groupings (for example, CBSA, State, and region). Alternatively, the commenter suggested that Ranking Criteria Five and Six be combined and become Ranking Criterion One, with the proposed Ranking Criterion One being redesignated as Ranking Criterion Two, and so forth. The commenter noted that, to the extent that an applying hospital is requesting slots because it is assuming or assumed an entire program, the new primary care Ranking Criterion One would "work in tandem" with the proposed rule's Ranking Criterion One.

Response: We believe that the commenter is requesting that points be assigned to a new teaching hospital that offers family medicine training without receipt of Medicare payment. However, we did not propose to create a point system under section 5506 as it did under section 5503. Furthermore, there is no need for us to provide additional preference to family medicine programs because we already provide preference for primary care programs under Ranking Criteria Five and Six. Because family medicine is also primary care, family medicine programs would receive preference under these ranking criteria. We also note that the commenter described an applying hospital that is assuming or assumed an entire program; therefore, it is possible that the commenter's hospital may already qualify under Ranking Criterion One, and additional preference for family medicine or primary care may not be necessary.

After consideration of the public comments we received, we are finalizing the following Ranking Criteria:

☐ *Ranking Criterion One. The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, possibly the same program director, and possibly the same (or many of the same) teaching staff).*

☐ *Ranking Criterion Two. The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. If the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed was with a hospital that itself has closed or is closing, preference would be given to an applying hospital that was listed as a participant in the next most recent Medicare GME affiliation agreement (but not one which was entered into more than 5 years prior to the hospital's closure) of which the first closed hospital was a member before the hospital closed, and that applying hospital received slots from the closed hospital under the terms of that affiliation agreement.*

☐ *Ranking Criterion Three. The applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training (that is, the applying hospital is permanently expanding its own existing programs).*

☐ *Ranking Criterion Four.* The applying hospital does not fit into Ranking Criteria One, Two, or Three, and will use additional slots to establish a new or expand an existing geriatrics residency program.

☐ *Ranking Criterion Five: Applying hospital does not meet Ranking Criterion One, Two, or Three, is located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program.*

☐ *Ranking Criterion Six: Applying hospital does not meet Ranking Criterion One, Two, or Three, is not located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program.*

☐ *Ranking Criterion Seven: Applying hospital seeks the slots for purposes that do not fit into any of the above ranking criteria.*

We are also finalizing the following policies with regard to the Ranking Criteria:

- For purposes of section 5506, we are stating that a hospital that takes on 90 percent of the residents training in a particular program at the closed hospital within 5 years prior to the hospital's closure or at the time of the hospital's closure would be deemed to have assumed an "entire" program.
- Under Ranking Criterion Two, we are only giving preference to hospitals that *received* slots from the closed hospital, under the terms of the Medicare GME affiliation agreement so that the hospital could continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement.
- Slots awarded under section 5506 may be used as part of the aggregate cap

in a Medicare GME affiliation agreement after five years from the date of their award.

6. Demonstrated Likelihood of Filling the Positions Within a Certain Time Period

Section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, does not place a limit on the number of slots an applying hospital may request, although under section 1886(h)(4)(H)(iv)(IV) of the Act, the Secretary must ensure that the aggregate number of increases to hospitals' FTE residents caps are equal to the FTE residents caps of the hospital that closed. However, section 1886(h)(4)(H)(iv)(III) of the Act specifies that the Secretary may only award slots to an applying hospital "if the Secretary determines that the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years." In the August 3, 2010 proposed rule (75 FR 46424), we proposed that hospitals *must provide documentation* to demonstrate the likelihood of filling requested slots under section 5506 within 3 years. For example, the applying hospital would document that it does not have sufficient room under its FTE resident caps to take in the additional residents, and has approval from the relevant accrediting body to take over the closed hospital's residency program(s), or expand its own residency program(s) to reflect a permanent commitment to train additional residents. We proposed that "within 3 years" would mean within the 3 academic years immediately following the application deadline to receive slots after a particular hospital closes. For example, where the application deadline is April 1, 2011, the immediately following academic year is July 1, 2011, and therefore, hospitals must demonstrate the likelihood of filling their slots by June 30, 2014.

We did not receive any public comments on this section, but as noted in response to a previous comment, we are adding to the Demonstrated Likelihood Criteria for section 5506 in this final rule that if the hospital has made a commitment to start a new program, or if the hospital is seeking approval from the relevant accrediting body to take over the closed hospital's residency program(s), the hospital may submit documentation that it has made a commitment to start a new program or take over the program(s), respectively.

7. No Duplication of FTE Cap Slots

Section 5506(d) of the Affordable Care Act specifies that "the Secretary shall give consideration to the effect of the amendments made by this section on any temporary adjustment to a hospital's FTE cap under § 413.79(h) * * * (as in effect on the date of enactment of this Act) in order to ensure that there is no duplication of FTE slots * * *." Under existing regulations at § 413.79(h), hospitals that take in residents that are displaced by the closure of another hospital may receive temporary increases to their FTE resident caps so that they may receive payment for training the specific displaced residents. The temporary cap adjustment lasts only for the duration of a specific displaced resident's training. In distributing slots permanently under section 5506, we may need to be cognizant of the number of FTE residents for whom a temporary FTE cap adjustment was provided, and when those residents will complete their training, at which point the temporary slot associated with those displaced residents would be available for permanent redistribution.

In the proposed rule, we stated that we believe it will only be necessary to delay permanent assignment of FTE cap slots in instances where if, after fulfilling the requests of hospitals that qualify to receive additional slots under Ranking Criteria One, Two, and Three, there are still excess slots available. In the case where an applying hospital fits within Ranking Criterion One, in the August 3, 2010 proposed rule (75 FR 46424), we proposed to revise the existing regulations at § 413.79(h) limiting temporary cap adjustments for displaced residents *by the number of FTE residents in the program(s) in which the applying hospital is operating seamlessly*. We proposed to immediately assign permanently that number of FTE slots to the qualifying hospital. For example, if teaching hospital B assumes an entire internal medicine program with 20 FTEs from closed hospital A, no temporary FTE cap adjustment under § 413.79(h) would be needed for those internal medicine residents, and teaching hospital B would immediately receive a permanent FTE resident cap increase of 10 FTE residents. Similarly, in the case where an applying hospital fits within Ranking Criterion Two, we proposed to revise the existing regulations at § 413.79(h) limiting temporary cap adjustments for displaced residents *by the number of FTE residents that the applying hospital received under the terms of the affiliation agreement from the closed hospital*. We proposed to immediately assign permanently that number of FTE slots to the qualifying hospital. For example, if teaching hospital D had received 30 FTE slots from closed hospital C under the terms of a Medicare GME affiliation agreement for the purposes of a shared rotational arrangement (as defined at § 413.75(b)) for a general surgery program, teaching hospital D would immediately receive a permanent FTE resident cap increase of 30 FTE residents, which would enable hospital D to continue to receive direct GME and IME payment for its share of training 30 general surgery residents.

Lastly, in the case where an applying hospital fits within Ranking Criterion Three, we proposed to revise § 413.79(h) to provide for temporary cap adjustments for displaced residents by *the number of displaced FTE residents the applying hospital takes in*, and to immediately assign permanently that number of FTE slots to the qualifying hospital. For example, if Hospital E takes in three FTE displaced residents in a family medicine program, and not only trains those three displaced residents until they complete their training, but permanently expands its existing family medicine program such that it will add three more FTEs in the place of three that completed their training, we would immediately assign three FTEs permanently to Hospital E, bypassing any temporary adjustment under § 413.79(h). Accordingly, there would be no duplication of FTE slots when distributing slots to hospitals that qualify under the first three ranking criteria.

If, after distributing the slots from a closed hospital to increase the FTE caps for applying hospitals that fall within Ranking Criteria One, Two, and Three, there are still excess slots available, it is possible that those excess slots might be associated with displaced residents for whom temporary cap adjustments under § 413.79(h) *are* necessary. That is, it is possible that in the case where applying hospitals do not permanently assume *all* of the closed hospital's residents and programs, temporary cap transfers under § 413.79(h) would be necessary to allow the remaining residents to complete their training. Therefore, we proposed to distribute the slots accordingly to increase the FTE resident caps for hospitals that fall within Ranking Criteria Four through Seven. However, to avoid duplicate FTE counting, we would only permanently assign the slots to the qualified hospitals falling within Ranking Criteria Four through Seven once the displaced residents have completed their training and their temporary cap adjustments have expired.

In the August 3, 2010 proposed rule (75 FR 46424), we proposed to add new regulations text at § 412.105(f)(1)(ix)(B)

for IME and § 413.79(o)(2) for direct GME to reflect the provisions of section 5506 of the Affordable Care Act. In addition, we proposed some very minor changes to direct GME and IME existing text in order to clarify meaning and standardize the terminology that is used throughout.

Comment: One commenter stated that CMS did not indicate in the proposed rule how the completion of displaced residents' training would be tracked and how this would effectuate the vacating of specific resident slots granted under Ranking Criteria Four through Eight. The commenter believed that it is "critically important that valuable residency slots" from closed hospitals that are not redistributed through Ranking Criteria One through Three should be redistributed to hospitals requesting a residency cap increase as quickly as possible. For this reason, the commenter recommended that CMS ensure that permanent resident cap increases awarded via Ranking Criteria Four through Eight are redistributed on an annual basis following the completion of their use for the purpose of supporting displaced residents.

Commenters also opposed CMS' proposal to subject FTE resident slots received under section 5506 from a closed hospital to the three-year rolling average count and inclusion in the IRB ratio cap. The commenters expressed specific concern about this issue in situations in which CMS proposed to make temporary, displaced resident slots available immediately on a permanent basis as under Ranking Criteria One through Three. The commenters stated that taking in additional residents may be costly, particularly if a hospital is taking on an entire program or multiple programs, and therefore, the rolling average payment methodology and the IRB ratio cap should not apply to hospitals qualifying under Ranking Criterion One until the time the slot is awarded to the hospital on a permanent basis, or at the earliest, at the beginning of the hospital's next fiscal year.

Response: On page 46424 of the August 3, 2010 proposed rule, we stated that we believe that it will only be necessary to delay permanent assignment of FTE cap slots in instances where if, after fulfilling the requests of hospitals that qualify to receive additional slots under Ranking Criteria One, Two, and Three, there are still excess slots available. In the case where an applying hospital fits within Ranking Criterion One, in the August 3, 2010 proposed rule (75 FR 46424), we proposed to revise the existing regulations at § 413.79(h) *limiting temporary cap adjustments for displaced residents by the number of FTE residents in the program(s) in which the applying hospital is operating seamlessly*. We proposed to immediately assign permanently that number of FTE slots to the qualifying hospital. For example, if teaching hospital B assumes an entire internal medicine program with 20 FTEs from closed hospital A, no temporary FTE cap adjustment under § 413.79(h) would be needed for those internal medicine residents, and teaching hospital B would immediately receive a permanent FTE resident cap increase of 20 FTE residents. Similarly, in the case where an applying hospital fits within Ranking Criterion Two, because the closed hospital had given slots to the applying hospital under an affiliation agreement, we proposed to immediately assign permanently that number of FTE slots to the qualifying hospital. For example, if teaching hospital D had received 30 FTE slots from closed hospital C under the terms of a Medicare GME affiliation agreement for the purposes of a shared rotational arrangement (as defined at § 413.75(b)) for a general surgery program, teaching hospital D would immediately receive a permanent FTE resident cap increase of 30 FTE residents, which would enable hospital D to continue to receive direct GME and IME payment for its share of training 30 general surgery residents. Lastly, in the case where an applying hospital fits within Ranking Criterion Three, we proposed to revise § 413.79(h) to immediately assign permanently that number of FTE slots to the qualifying hospital. For example, if Hospital E takes in three FTE displaced residents in a family medicine program, and not only trains those three displaced residents until they complete their training, but permanently expands its existing family medicine program such that it will add three more FTEs in the place of three that completed their training, we would immediately assign three FTEs permanently to Hospital E, bypassing any temporary adjustment under § 413.79(h). Accordingly, there would be no duplication of FTE slots when distributing slots to hospitals that qualify under the first three ranking criteria.

In this final rule, we are making limited modification to our proposal regarding the overriding of the temporary cap adjustment regulations at § 413.79(h) for Ranking Criteria One through Three. We had proposed that in each of these three Ranking Criteria, we would "immediately" assign permanently the number of applicable slots to the qualifying hospital. However, we realize that taking in more residents may be costly for a hospital. We also want to implement section 5506 in a manner that is the most administratively feasible, particularly in terms of how the adjustments are to be reported on the Medicare cost report, while also distributing the slots and allowing them to take effect as soon as possible. Therefore, *except* for the case of a brand new hospital taking over a program(s), or an acquisition which we describe under the definition of "hospital closure" (75 FR 46422), where the new owner receives a new provider agreement and operates the hospital exactly as it had been operated prior to the acquisition, we believe that it would still be appropriate to allow a hospital that ultimately would qualify to receive slots permanently under any of the ranking criteria and that took in displaced residents to receive temporary cap adjustments and, in a limited manner, exemptions from the rolling average and IRB ratio cap (subject to the regulations at § 412.105(a)(1)(iii)). As a general rule, even if we do not make the determination as to which hospitals will receive the slots until sometime after the hospital closes, the effective date of the permanent cap adjustments to an applying hospital would be the date of the hospital's closure. However, for administrative ease, in that first cost reporting period in which the applying hospital takes in displaced residents and the hospital closure occurs, the applying hospital could receive a temporary cap adjustment, an exemption from the rolling average, and an exemption from the IRB ratio cap for the displaced residents. Then, as the commenters recommended, effective beginning with the cost reporting period *following* the one in which the hospital closure occurred, the applying hospital's permanent cap increase would take effect, and there would be no rolling average exemption (and no IRB ratio cap exemption in accordance with the *existing* regulations at § 412.105(a)(1)(iii), which state that the exception from the IRB ratio cap applies only through the end of the first 12-month cost reporting period in which the receiving hospital trains the displaced FTE residents). If the hospital closure and CMS' determination as to whether a particular applying hospital receives a permanent cap increase occur within the same cost reporting period for the applying hospital, and the applying hospital takes in displaced residents, then again, the applying hospital could receive a temporary cap adjustment, an exemption from the

rolling average, and an exemption from the IRB ratio cap only until the end of that cost reporting period. Effective beginning with the following cost reporting period, the permanent cap would apply and there would be no exemption from the rolling average (or IRB ratio cap). Following is an example of how this policy regarding the effective date of the permanent cap increases and the exemption from the rolling average and IRB ratio cap would work under section 5506:

Hospital Q closes on February 28, 2009. Hospital R, which has a December 31, 2009 fiscal year end (FYE), assumes Hospital Q's orthopedic program which is accredited for 6 positions, and 6 FTE residents are still training at Hospital Q at the time Hospital Q closes. Thus, these 6 FTEs are displaced and they transfer to Hospital R on March 1, 2009. Hospital R has an FTE resident cap of 50, and has been training approximately 50 FTEs for the past 3 years. Hospital R receives a temporary cap adjustment for the 6 displaced FTEs, which would equate to a prorated cap adjustment of 5 for the period between March 1, 2009 and December 31, 2009. For the IME calculation in its FYE December 31, 2009 cost report, Hospital R may add a prorated count of 5 FTEs after the rolling average calculation to the numerator of its IRB ratio. Hospital R may also increase the numerator of its FYE December 31, 2008 IRB ratio by 5 FTEs, so as not to be held to the IRB ratio cap (in accordance with the existing regulations at § 412.105(a)(1)(iii)). For the direct GME calculation in its FTE December 31, 2009 cost report, Hospital R would also add 5 FTEs after the nonprimary care rolling average calculation. Thus, Hospital R's payment should reflect about 5 FTEs for IME and direct GME, respectively, in FYE December 31, 2009.

The displaced orthopedic residents continue training at Hospital R in Hospital R's FYE December 31, 2010 and December 31, 2011 cost reporting periods (that is, these are not new orthopedic residents that Hospital R has recruited), and Hospital R has continued to report the displaced residents after the rolling average calculation on the Medicare cost report. On April 1, 2011, Hospital R applies for 6 slots under Ranking Criterion One. On November 5, 2011, CMS determines that Hospital R may receive a permanent increase to its cap of 6 FTEs, raising its FTE resident cap from 50 to 56. Hospital R continues to train approximately 50 other FTEs. Effective with its cost reporting period beginning on January 1, 2010, the permanent cap increase of 6 takes effect, and the displaced orthopedic FTEs *must be included* in the rolling average calculation of the Medicare cost reports for FYE December 31, 2010 and December 31, 2011.

As explained above, the policy is similar if the dates of the hospital closure and CMS's determinations of permanent cap assignments are in the same cost reporting period. For example, Hospital S closes on February 1, 2012. Hospital T, who has a December 31 FYE, assumes several programs and applies for slots under Ranking Criterion One. CMS determines that Hospital T receives a permanent cap increase on October 1, 2012. Hospital T may receive a temporary cap adjustment, an exemption from the rolling average calculation, and an exemption from the IRB ratio cap on its FYE December 31, 2012 cost report. On its FYE December 31, 2013 cost report, Hospital T would report a permanent cap increase and any remaining displaced residents would be included in the rolling average calculation. During the process of reviewing the applications for slots after a hospital closes, be it for hospitals that have already closed between March 23, 2008 and August 3, 2010 (the first round of applications), or for future hospital closures, we would still assign the slots to hospitals qualifying under Ranking Criteria One, Two, and Three in descending order. We agree with the commenter that it is very important that the residency slots from closed hospitals that are not redistributed through Ranking Criteria One through Three should be redistributed to hospitals requesting a residency cap increase as quickly as possible.

The commenter recommended that CMS ensure that permanent resident cap increases awarded via Ranking Criteria Four through Eight are redistributed on an annual basis following the completion of their use for the purpose of supporting displaced residents. First, we note that in this final rule, we have consolidated and reduced the number of Ranking Criteria from Eight to Seven. The slots that we would be distributing could be based on slots attributable to displaced residents for which the temporary cap adjustments to their receiving hospitals would expire upon graduation of those residents from their programs. We would have to hold these slots in reserve, and release them for permanent assignment to qualifying hospitals on an annual basis, as the commenter suggests, as each of those residents graduates. With each hospital closure, we will request and receive information from the closed hospital if possible, from the Medicare contractors, and the hospitals that take in the displaced residents, regarding, at a minimum, the FTE number of residents that are displaced, the programs the residents are in, and the program year in which each resident was at the time of the hospital closure, which would help us determine the number of years each displaced resident has to complete his or her training. Using this information, at the time that we are reviewing the applications, we will determine the point (typically July 1) at which each qualifying hospital will receive the FTEs permanently, and we will inform the qualifying hospital that effective with a certain graduation date, possibly in the past, but likely in the future, the qualifying hospital's FTE resident caps would be permanently increased by a specified number, as appropriate. When that graduation date arrives, the permanent cap increase will occur automatically for the qualifying hospital—the hospital need not wait for further adjudication by CMS. Depending on the length of the particular program and the number of years left for the displaced residents to train, it may take several years (that is, several graduation dates) until a hospital receives its full cap increase under section 5506. In this way, although some hospitals will not receive their total permanent cap increases "immediately," they will at least know the date(s) in the future that they will receive their permanent cap adjustments, and those cap adjustments will occur automatically. Of course, because residents who are closer to the completion of their program at the time they are displaced by the hospital closure will graduate sooner than those residents closer to the beginning of their training, their FTE slots are more "valuable." We would assign the slots of those residents graduating sooner to those hospitals ranked higher, in descending order.

The following example illustrates how the permanent assignment of slots would be effectuated when displaced residents are involved. Hospital G has an FTE resident cap of 8 and closes on December 31, 2010. It had 8 residents in an internal medicine program. Hospital J currently has an internal medicine program with 15 residents, and wants to expand it permanently, and on January 1, 2011, Hospital J expands its internal medicine program and seamlessly assumes 5 internal medicine residents from Hospital G. The remaining 3 internal medicine residents are accepted by hospitals in various locations solely to complete their training. In the section 5506 application process, Hospital J is located in the same CBSA as Hospital G and it applies for 5 slots and qualifies

to receive those slots under Ranking Criterion Three. Assume CMS determines on January 1, 2012 that Hospital J may receive those slots permanently. Hospital J has a September 30 FYE. Hospital J had been receiving temporary cap adjustments and the exemption from the rolling average and the IRB ratio cap for the 5 FTEs for its cost reporting period ending September 30, 2011. On January 1, 2012, the FTE cap adjustment is permanent for Hospital J's entire FYE September 30, 2012 cost report, and the exemption from the rolling average does not apply to Hospital J's FYE September 30, 2012 cost report. Of the 3 displaced residents, John Doe, was a PGY1 when Hospital G closed, and is expected to graduate on June 30, 2013. Jane Doe was a PGY2 and is expected to graduate on June 30, 2012. Kreshen Doe was a PGY3 and is expected to graduate on June 30, 2011. Hospital M is also located in the same CBSA as Hospital G, which is a HPSA, and applies to receive 1 slot under Ranking Criterion Five to expand a primary care program. Hospital N is located in a CBSA that is contiguous to the CBSA that Hospital G is located in, it is not located in a HPSA, and is requesting 1 slot under Ranking Criterion Six to expand a primary care program. Hospital P is located in the same State but not the same CBSA as Hospital G, and applies under Ranking Criterion Four for 1 slot to start a geriatrics fellowship.

On January 1, 2012, CMS determines that Hospital M receives the slot associated with PGY3 Kreshen Doe, who finished his training at another hospital on June 30, 2011. (The hospital that took in Kreshen Doe until he finished his training received a temporary cap adjustment under § 413.79(h), which ended on June 30, 2011). Thus, Hospital M's permanent FTE cap increase is effective July 1, 2011. On January 1, 2012, CMS also determines that Hospital N will receive the slot associated with PGY2 Jane Doe, and we inform Hospital N that its FTE cap will increase permanently effective July 1, 2012. Finally, on January 1, 2012, CMS determines that Hospital P will receive the slot associated with PGY1 John Doe, and we inform Hospital P that its FTE cap will increase permanently effective July 1, 2013. (We note that this example is for illustrative purposes only and we are not implying that all cap determinations and assignments would be made according to the timeline used in this example).

The example above described how the slots would be awarded permanently on an annual basis under Ranking Criteria Four through Seven in the instance where temporary cap increases are being used in accordance with § 413.79(h) by various hospitals and we would need to ensure that those residents graduated before permanently assigning the slots to avoid duplication in the FTE caps. In the scenario where a hospital closes but for whatever reason, there are no hospitals that receive temporary cap adjustments under § 413.79(h), the effective date of the permanent cap increases would be prospectively from the date of the determination. For example, a hospital closes on April 30, 2013. Another hospital applies under Ranking Criterion Six and will use all the requested slots to start a general surgery program. The hospital shows that it can meet the demonstrated likelihood requirements to fill those slots. We determine on January 15, 2014 that the hospital may receive the slots, and its permanent cap increase is effective on January 15, 2014.

We will be making changes to the Medicare cost report, Worksheet E, Part A for IME, and Worksheet E–3, Part IV for direct GME, (and Worksheet E–4, the direct GME worksheet on CMS–2552–10), to accommodate the increases to the FTE resident caps of hospitals that receive slots under section 5506.

Comment: One commenter support CMS' implementation of the Congressional mandate that there be no duplication of FTE cap slots as provided at section 5506(d). The commenter asked that the Secretary give greater priority to hospitals that could have availed themselves of the application of temporary cap adjustments at § 413.79(h) but did not because, in this instance, there is "good assurance" that there is no duplication of FTE slots.

Response: We believe that the commenter misunderstood the Congressional mandate that there be no duplication of FTE slots as provided at section 5506(d). This Congressional mandate applies not only to the hospital applying for slots or that took over the program, but rather it applies across all hospitals. It is important to note that although the commenter's hospital may not have availed itself to temporary cap adjustments at § 413.79(h), other hospitals may have taken in residents and received temporary cap adjustments for the same program. Therefore, slots associated with that program cannot be distributed permanently until it is known that any and all temporary cap adjustments for those slots have expired.

After consideration of public comments we received, we are revising our proposal regarding the application of the rolling average and the IRB ratio cap. Specifically, *except* for the case of a brand new hospital taking over a program(s), or an acquisition which we describe under the definition of "hospital closure" (75 FR 46422), where the new owner receives a new provider agreement and operates the hospital exactly as it had been operated prior to the acquisition, we believe that it would still be appropriate to allow a hospital that ultimately would qualify to receive slots permanently under any of the ranking criteria and that took in displaced residents to receive temporary cap adjustments and, in a limited manner, exemptions from the rolling average and IRB ratio cap (subject to the regulations at § 412.105(a)(1)(iii)), as discussed above.

8. Other Payment Issues Regarding Hospitals that Receive Increase in FTE Caps Based on Slots from Closed Hospitals

In the proposed rule, we noted that section 1886(h)(4)(H)(vi) of the Act, as added by the Affordable Care Act, makes no reference to section 1886(h)(4)(G) or 1886(d)(5)(B)(vi)(II) of the Act, which are the provisions concerning the rolling average count of FTE residents. Furthermore, there is no mention of section 1886(d)(5)(B)(vi)(I) of the Act, the provision regarding the cap on the IME resident-to-bed ratio, in section 1886(h)(4)(H)(vi) either. That is, the statute does not provide for an exclusion from application of the rolling average for residents counted as a result of FTE cap increases under section 1886(h)(4)(H)(vi) of the Act, nor does the statute exempt these residents from the application of the cap on the IME resident-to-bed ratio. In light of the absence of a specific directive in section 1886(h)(4)(H)(vi) of the Act exempting those residents from application of the rolling average for direct GME and IME, and the cap on the IME resident-to-bed ratio, and with no apparent reason to treat residents counted as a result of the FTE cap increases under section 1886(h)(4)(H)(vi) of the Act differently, in the August 3, 2010 proposed rule (75 FR 46425), we proposed to require that if a hospital increases its direct GME or IME FTE count of residents as a result of an FTE resident cap increase under section 1886(h)(4)(H)(vi) of the Act, those FTE residents would be immediately subject to the rolling average calculation and the cap on the IME resident-to-bed ratio.

We also note that section 1886(h)(4)(H)(vi) of the Act for direct GME and section 1886(d)(5)(B)(v) of the Act for IME does not specify use of a special direct GME PRA or IME multiplier for residents counted by a hospital under an FTE cap increase

received after the closure of another hospital. Therefore, we proposed that residents counted by a hospital under a permanent adjustment to the hospital's FTE resident caps under the provisions of section 5506 of the Affordable Care Act would be paid for using the receiving hospital's otherwise applicable direct GME PRA (which is hospital-specific) and IME multiplier (which is the same for all hospitals). (Further, as we proposed with respect to FTE resident cap increases awarded under section 5503 (section XXI.D. of this preamble), we proposed that these slots may not be used as part of the aggregate FTE resident cap under a Medicare GME affiliation agreement. However, as we explained in response to comments above, we are allowing slots awarded under section 5506 to be included in a Medicare GME affiliation agreement after a 5-year period).

Comment: Commenters opposed CMS' proposal to subject FTE resident slots received under section 5506 from a closed hospital to the three-year rolling average count and inclusion in the IRB ratio cap under Ranking Criteria One through Three.

Response: As we explained above in response to comments under the "No Duplication of FTE Slots" section, in this final rule, we are modifying our proposed position regarding the rolling average and the IRB ratio cap. Specifically, except for the case of a brand new hospital taking over a program(s), or an acquisition which we describe under the definition of "hospital closure" (75 FR 46422), where the new owner receives a new provider agreement and operates the hospital exactly as it had been operated prior to the acquisition, we believe that it would still be appropriate to allow a hospital that ultimately would qualify to receive slots permanently under any of the Ranking Criteria and that took in displaced residents to receive temporary cap adjustments and, in a limited manner, exemptions from the rolling average and IRB ratio cap (subject to the regulations at § 412.105(a)(1)(iii)).

Comment: Two commenters requested clarification regarding which direct GME PRA and IME intern-and-resident to bed (IRB) ratio cap would be used for the hospital assuming the programs of the closed hospital, particularly if the hospital assumed *all* of the residency programs from the closed hospital.

Response: In the case where a hospital assumes the programs of a closed hospital, and seamlessly operates those programs on the same site as the closed hospital, but did not assume the provider agreement of the closed hospital, it is then a new hospital, and therefore does not have its own PRA or resident and bed history for use in the IRB ratio cap. A new PRA would have to be calculated in accordance with regulations at § 413.77(e), and the IRB ratio cap would not apply for the new hospital's first cost reporting period under § 412.105(f), but would apply for the hospital's second cost reporting period. Furthermore, in the new hospital's first cost reporting period, there would be no rolling average calculation, and in the second cost reporting period, there would be a 2-year rolling average calculation. In the third cost reporting period, the rolling average would be based on three years of cost report data. However, in the case where a hospital assumes one or more programs and does not operate them on the site of the closed hospital, but instead operates the program(s) on the site of its own hospital, then the PRA of the applying hospital would be used, and the bed counts and FTE counts of the applying hospital would be used in the IRB ratio cap calculation.

9. Other Comments and Responses Regarding Section 5506

Comment: Two commenters noted that section 5506 appears to be silent as to whether, if a closed hospital also received slots under section 422 of the MMA, those 422 slots are subject to redistribution under section 5506 along with the closed hospital's 1996 FTE resident cap slots. The commenters believed Congress intended for all residency cap slots to be redistributed from a closed hospital including section 422 slots. One commenter recognized that the IME adjustment and the direct GME Per Resident Amount to be used for section 422 cap slots differs from the rates used for regular cap slots, which could make the 422 cap slots less attractive to qualifying hospitals. Therefore, the commenter encouraged CMS to consider distributing the 422 slots last (to hospitals lower in the priority order).

Response: We agree with the commenter. In implementing section 1886(h)(4)(H)(vi)(IV) of the Act, we proposed to interpret "the number of resident positions" to mean the number that is equal to the IME and direct GME FTE resident caps of a hospital that closed, or will close. Because section 422 of the MMA provided many hospitals with additional IME and/or direct GME FTE resident cap slots, those additional cap slots will also be subject to redistribution under section 5506. As the commenter mentioned, the IME adjustment and the direct GME PRA used for section 422 cap slots differs from the rates used for regular cap slots, making the section 422 cap slots "less attractive" to qualifying hospitals. Accordingly, we agree with the commenter's suggestion to distribute section 422 slots only after all regular cap slots from the closed hospital are assigned for redistribution. However, hospitals that receive section 422 slots under section 5506 would be paid for those slots using the section 422 direct GME PRA and IME multiplier. If a hospital that closes has both regular FTE caps and section 422 caps, we envision the redistribution of all those cap slots in the following method. We would review and rank the applications and assign as many regular slots as we can to qualifying hospitals based on the ranking order, in a descending manner. Once the regular slots are all assigned, we would then assign all the section 422 slots, continuing to follow the ranking priorities in descending order. If the remaining number of requests for slots from qualified hospitals of equal rank exceeds the amount of section 422 cap slots available, we would prorate the remaining section 422 slots among those equally ranked hospitals (the same way we would prorate the remaining regular FTE cap slots in the instance where a closed hospital only had regular FTE cap slots but the requests exceed the number of regular FTE cap slots available). We would prorate as follows: [(total number of available slots remaining/total number of requested slots remaining) × number of slots requested by Hospital A] and [(number of slots remaining/total number of requested slots remaining) × number of slots requested by Hospital B] and so forth.

It could also be possible that, in distributing the slots from a single closed hospital that had section 422 cap slots, there may not be sufficient regular cap slots to satisfy all the requests from hospitals of equal rank, in which case we would have to prorate both the regular cap slots and the section 422 cap slots. For example, assume Closed Hospital had a 1996 FTE cap of 50, and a section 422 FTE cap of 25. After ranking all the applicants, we assign 40 of the slots to qualified hospitals without any proration. Ten of the 1996 FTE cap slots remain, while requests for 50 slots from Hospitals Y and Z of equal rank still remain as well. Hospital Y requested and qualifies for 30 slots and Hospital Z requested and qualifies for 20 slots. In this case, we would prorate and assign the remaining ten 1996 FTE cap slots as follows: [(total number of available 1996 slots remaining/total number of requested slots remaining) × number of slots requested by Hospital

Y] and [(total number of available 1996 slots remaining/total number of requested slots remaining) × number of slots requested by Hospital Z] etc. In this example, this would mean: [(10/50) × 30] = 6 of the 1996 slots for Hospital Y, and [(10/50) × 20] = 4 of the 1996 slots for Hospital Z. Thus, only 10 out of the 50 requested slots have been assigned to Hospitals Y and Z (Hospital Y has 24 requested slots unfulfilled, and Hospital Z has 16 of its requested slots unfulfilled), and there are still 25 section 422 cap slots available. We would prorate the 25 section 422 slots to Hospitals Y and Z as follows: [(number of section 422 slots remaining/total number of requested slots remaining) × remaining number of slots requested by Hospital Y] and [(number of section 422 slots remaining/total number of requested slots remaining) × remaining number of slots requested by Hospital Z]. In this example, this would mean: [(25/40) × 24] = 15 of the section 422 slots for Hospital Y, and [(25/40) × 16] = 10 of the section 422 slots for Hospital Z.

It is also important to consider how the redistribution process would work in the instance where a hospital that closes is training residents above its FTE caps at the time it closes, and there are multiple hospitals that assume an entire program or programs from that closed hospital. In such a case, not only will the number of requested slots from all applicants exceed the amount of FTEs in the FTE caps of the hospital that closed, but the number of FTE residents that are being assumed also exceeds the closed hospital's FTE caps. For example, a closed hospital was training 700 FTE residents, but its FTE resident cap was 500. Hospital K assumes the entire program for 680 FTEs, and Hospital L assumes one program of 20 FTEs. Both hospitals qualify under Ranking Criterion One. As a first step, before we begin to assign any slots to the qualified applicants, we would first prorate *each* of the qualified applicants' requests. We would then prorate the closed hospital's IME and direct GME FTE caps as follows:

Hospital K: (680 FTEs assumed/700 total FTEs) × closed hospital's FTE resident cap of 500 = 485.71 slots.

Hospital L: (20 FTEs assumed/700 total FTEs) × closed hospital's FTE resident cap of 500 = 14.29 slots.

485.71 + 14.29 = 500.

Comment: One commenter stated that they understand that by law they can only receive a permanent cap for interns and residents from hospitals that closed or close on or after March 23, 2008. However, the commenter recommended that in future rulemaking CMS should take into consideration hospitals that have consistently taken in interns and residents from closed hospitals (and are over their cap) prior to March 23, 2008 and make those temporary cap adjustments into permanent caps.

Response: We appreciate this suggestion to consider hospitals that have consistently taken in interns and residents from closed hospitals prior to March 23, 2008 in future rulemaking. However, as noted by the commenter, CMS is bound by statute in this instance and thus can only make permanent cap adjustments as a result of hospitals that have closed on or after March 23, 2008.

Comment: Commenters asked CMS to clarify whether a nonteaching hospital that takes displaced residents and receives permanent cap slots through the closed hospital redistribution program may still start a new program under § 413.79(e) and proceed through the normal 3-year process of building a permanent resident cap.

Response: Whether a nonteaching hospital could receive slots under section 5506 and still not be precluded from still qualifying for a new program cap adjustment under § 413.79(e) depends upon which ranking criteria the hospital applies for slots under 5506. In the instance where a non-teaching hospital is assuming entire program(s) and receives a permanent cap increase for the program(s) under Ranking Criterion One, we do not believe that hospital should still have the opportunity to receive a further cap increase under § 413.79(e). Such a hospital should decide whether it wants to assume an entire existing program(s) from a closed hospital and receive slots under section 5506, or whether it wants to reserve its rights to start new programs and therefore, not request (and receive) slots under section 5506. Nonteaching hospitals that would qualify to request slots under the other ranking criteria could still qualify to start new programs and receive a cap increase under § 413.79(e). In general, we note that if a non-teaching hospital is simply interested in starting a new program and qualifies for a new program cap adjustment under § 413.79(e), the non-teaching hospital should not be applying for slots under 5503 or 5506 for the FTEs in the new program, because there is no need for it to do so. It would receive slots under the normal mechanism for new teaching hospitals, in accordance with the regulations at § 413.79(e).

Comment: One commenter stated that CMS should clearly specify that a hospital operating below its cap at the time it began training displaced residents, and thus did not receive a temporary increase in its cap under the existing rules, would be considered under section 5506. The commenter noted that a hospital may subsequently implement a plan to expand enrollment in its existing program, causing it to operate above its cap. The commenter expressed that this concern is particularly salient for New York hospitals that participated in the New York Medicare GME Demonstration Program.

Response: All hospitals requesting slots under section 5506 will be considered when distributing slots from a closed hospital. It is quite possible that a hospital could qualify for a cap adjustment under section 5506 even if it did not receive a temporary cap increase at the time it began training displaced residents, because at that time, it had room below its caps. A hospital that accepted displaced residents in the past from a hospital or program that closed would only have been eligible to receive a temporary cap adjustment if it was already training residents in excess of its caps. Subsequent to accepting those displaced residents, the hospital may decide to permanently expand the number of residents it is training to an amount in excess of its caps. If such a hospital can show a demonstrated likelihood to fill slots within 3 years, and if the applying hospital can show that it is expanding in excess of its caps, then the applying hospital could apply under section 5506, but only for the incremental amount in excess of its caps that is needed. It is important to note, therefore, that a hospital that currently has room under its caps to expand its program to a level that it desires would not be considered for receipt of additional slots under section 5506.

10. Application—No Reopening of Settled Cost Reports

Section 5506(c) of the Affordable Care Act specifies that the changes made by the provisions of sections 5506(a) and (b) should not be applied in a manner that would require the reopening of settled cost reports for which there is not a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010 (the date of the enactment of Pub. L. 111–148). In the August 3, 2010 proposed rule (75 FR 46425), we proposed to reflect this provision in the proposed revisions under § 412.105(f)(1)(ix)(B) and § 413.79(o)(2)(ii) of the regulations. We proposed to interpret "jurisdictionally proper appeal pending" on direct GME or IME payments to mean that in order for a hospital to request a change to its FTE count, direct GME or IME

respectively, the "jurisdictionally proper appeal pending" must be specific to direct GME or IME respectively. For example, in order for a hospital to increase its FTE count with regard to an Affordable Care Act provision that is unique to IME (such as inclusion in the IME count of didactic time occurring in the hospital as specified by new section 1886(d)(5)(B)(x)(II) of the Act), the hospital's "jurisdictionally proper appeal pending" must be on an IME issue; IME FTEs or the available bed count. However, if the hospital's "pending, jurisdictionally proper appeal" is on an issue that only affects direct GME payments, such as the initial residency period or the Medicare patient load, that appeal would not be sufficient in order for the hospital to increase its FTE count with regard to an Affordable Care Act provision that is unique to IME, such as didactic time in the hospital setting.

We did not receive any public comments specific to this section. However, after reviewing public comments received regarding the "No Duplication of FTE Slots" proposal, and the timing and effective dates of slots awarded permanently under section 5506, we have reconsidered the manner in which we interpreted section 5506(c) of the Affordable Care Act. Because section 5506 was enacted on March 23, 2010, and instructs the Secretary to redistribute slots from teaching hospitals that closed on or after March 23, 2008, there are some retroactive aspects to this provision. Furthermore, as we explained in response to comments above in the section on "No Duplication of FTE Slots," there are instances where we would determine that an applying hospital's FTE resident cap would increase permanently effective with the fiscal year begin date of the cost reporting period that follows the cost reporting period in which the closure occurred. In contemplating the meaning and implications of section 5506(c), we have considered that, particularly for closures that occurred in 2008 or 2009, it is possible that those cost reporting periods are closed, and 180 days since the Notice of Program Reimbursement (NPR) was issued has passed as well. Section 5506(c) states that the provision should not be applied in a manner that would require the reopening of settled cost reports for which there is not a pending, jurisdictionally proper appeal on direct GME or IME payments as of March 23, 2010. Therefore, section 5506(c) reminds the Secretary that in the absence of an appeal on the 2008 or 2009 cost report of the applying hospital, the Medicare contractor would not assign a permanent cap increase to cost reports that are beyond the 180-day appeal period. Instead, the permanent cap increase would take effect on the next cost report that has not yet been settled.

11. No Administrative or Judicial Review Under Section 5506

We inadvertently omitted a discussion from the proposed rule regarding section 5506(e), which amended section 1886(h)(7)(E) of the Act (as also amended by section 5503(a)) to state, "There shall be no administrative or Judicial review * * * with respect to determinations made under this paragraph, paragraph (8), or paragraph (4)(H)(vi)." The fact that Congress included this language clearly means that the Congress intended for our determination with regard to FTE resident cap redistributions under section 1886(h)(4)(H)(vi) of the Act as added by section 5506(a) to be final, and not subject to appeal. Because of this statutory language, we do not believe it would be appropriate to allow hospitals (or CMS) to appeal determinations concerning the FTE cap redistributions under section 1886(h)(4)(H)(vi) of the Act.

LIST OF TEACHING HOSPITALS THAT HAVE CLOSED ON OR AFTER MARCH 23, 2008 AND BEFORE AUGUST 3, 2010

Provider No.	Provider name	Terminating date	DGME cap	IME cap	Sec. 422 Increase/ decrease DGME	Sec. 422 Increase/ decrease IME	CBSA
01–0064	Physicians Carraway Medical Ctr	11/01/2008	65.08	65.08	−4.5	−4.5	13820
03–0017	Mesa General Hospital	05/31/2008	20.52	13.33	0.00	0.00	38060
14–0075	Michael Reese Hospital	06/11/2009	199.52	200.82	0.00	0.00	16974
15–0029	St. Joseph Hospital Mishawaka	07/01/2008	13.43	7.68	−3.79	−1.23	43780
19–3034	Touro Rehabilitation Center	12/31/2009	3.20	2.99	0.00	0.00	35380
26–4011	Mid-Missouri Mental Health Center	06/30/2009	5.33	1.25	0.00	0.00	17860
31–0063	Muhlenberg Regional Medical Center	08/13/2008	30.17	30.17	0.00	0.00	35620
31–0088	William B Kessler Memorial Hospital	03/12/2009	2.00	2.00	0.00	0.00	12100
33–0133	Cabrini Medical Center	06/16/2008	134.01	124.1	−21.36	−23.83	35644
33–0357	Caritas Health Care, Inc	03/06/2009	190.23	190.23	−9.40	−9.40	35644
33–0390	North General Hospital	07/10/2010	57.17	54.29	−6.23	−4.08	35644
39–0023	Temple East Hospital	06/28/2009	2.36	2.36	0.00	0.00	37964
39–0169	Geisinger South Wilkes-Barre	07/10/2009	4.00	3.33	0.98	1.67	42540
42–0006	Charleston Memorial Hospital	11/25/2008	40.88	40.83	0.00	0.00	16700

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CMS Evaluation Form

As Part of the Application for the Increase in a Hospital's FTE Cap(s) under Section 5506 of the Affordable Care Act: Preservation of FTE Cap Slots from Teaching Hospitals that Close

Directions: Please fill out the information below for each residency program for which the applicant hospital intends to use the increase in its FTE cap(s). The applicant hospital is responsible for complying with the other requirements listed in the CY 2011 Hospital Outpatient Prospective Payment System rule in order to complete its application for the increase in its FTE cap(s) under section 5506 of Public Law 111-148.

NAME OF HOSPITAL: _____

MEDICARE PROVIDER NUMBER: _____

NAME OF MEDICARE CONTRACTOR: _____

NAME OF SPECIALTY TRAINING PROGRAM: _____

(Check one): □ Allopathic Program □ Osteopathic Program

NUMBER OF FTE SLOTS REQUESTED FOR PROGRAM:

Direct GME: _____ **IME:** _____

Section A: Demonstrated Likelihood of Filling the FTE Slots

Demonstrated Likelihood: Hospital must provide documentation to demonstrate the likelihood of filling requested slots under section 5506 within 3 years. For example, the applying hospital would document that it does not have sufficient room under its FTE resident caps to take in the additional residents, and has approval from the relevant accrediting body to take over the closed hospital's residency program(s), or

expand its own residency program(s) to reflect a permanent commitment to train additional residents.

(1) The hospital does not have sufficient room under its direct GME FTE cap or IME FTE cap, or both, and will establish a newly approved residency program. **(The hospital must check at least one of the following, if applicable.)**

□ Application for approval of the new residency program has been submitted to the ACGME, AOA or the ABMS. **(The hospital must attach a copy.)**

□ The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program. **(The hospital must attach a copy.)**

□ The hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the new or expanded program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). **(The hospital must attach a copy.)**

- The hospital may submit documentation demonstrating that it has made a commitment to start a new program.

(2) Hospital does not have sufficient room under its direct GME FTE cap or IME FTE cap, or both, and has or is seeking approval from the relevant accrediting body to take over the closed hospital's residency program(s), or expand its own residency program(s) to reflect a permanent commitment to train additional residents. (**The hospital must check at least one of the following, if applicable.)**

□ Application for approval of the residency program has been submitted to the ACGME, AOA or the ABMS. **(The hospital must attach a copy.)**

□ The hospital has submitted an institutional review document or program information form concerning the program in an application for approval of the program. **(The hospital must attach a copy.)**

□ The hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the program, or other types of communication from the accrediting bodies concerning the program approval process (such as notification of site visit). **(The hospital must attach a copy.)**

- The hospital is seeking approval from the relevant accrediting body to take over the closed hospital's residency program(s), and the hospital may submit documentation demonstrating that it has made a commitment to take over the program(s).

(3) Hospital will likely fill the slots requested. **(The hospital must check the following, if applicable.)**

□ The hospital does not have sufficient room under its direct GME FTE cap or IME FTE cap, or both. **(Copies of EACH of the following must be attached.)**

- Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor documenting on Worksheet E, Part A, Worksheet E-3, Part IV, and Worksheet E-3, Part VI the resident counts and FTE resident caps for both direct GME and IME.

(4) Applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed

hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. If the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed was with a hospital that itself has closed or is closing, the applying hospital was listed as a participant in the next most recent Medicare GME affiliation agreement (but not one which was entered into more than 5 years prior to the hospital's closure) of which the first closed hospital was a member before the hospital closed, and that applying hospital received slots from the closed hospital under the terms of that affiliation agreement. **(Copies of EACH of the following must be attached.)**

- Copies of the recent Medicare GME affiliation agreement of which the applying hospital and the closed hospital were a member of before the hospital closed.
- Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor documenting on Worksheet E, Part A, Worksheet E-3, Part IV and Worksheet E-3, Part VI the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.
- Copies of the most recent accreditation letters for all of the hospital's training programs in which the hospital had a shared rotational arrangement (as defined at §413.75(b)) with the closed hospital.

Section B. Level Priority Category

(Place an "X" in the appropriate box that is applicable to the level priority category that describes the applicant hospital.)

- □ First, to hospitals located in the same core-based statistical area (CBSA) as, or in a CBSA contiguous to, the hospital that closed.
- □ Second, to hospitals located in the same State as the closed hospital.
- □ Third, to hospitals located in the same region as the hospital that closed.
- □ Fourth, if the slots have not yet been fully distributed, to qualifying hospitals in accordance with the criteria established under section 5503, "Distribution of Additional Residency Positions"

Section C. Evaluation Criteria

(Place an "X" in the box for each criterion that is appropriate for the applicant hospital and for the program for which the increase in the FTE cap is requested.)

□ Ranking Criterion One. *The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, possibly the same program director, and possibly the same (or many of the same) teaching staff).*

□ Ranking Criterion Two. *The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and*

under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. If the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed was with a hospital that itself has closed or is closing, preference would be given to an applying hospital that was listed as a participant in the next most recent Medicare GME affiliation agreement (but not one which was entered into more than 5 years prior to the hospital's closure) of which the first closed hospital was a member before the hospital closed, and that applying hospital received slots from the closed hospital under the terms of that affiliation agreement.

□ Ranking Criterion Three. *The applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training (that is, the applying hospital is permanently expanding its own existing programs).*

□ Ranking Criterion Four. *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, and will use additional slots to establish a new or expand an existing geriatrics residency program.*

1. Ranking Criterion Five*: The applying hospital does not meet ranking criterion 1, 2, or 3, is located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program.*

2. Ranking Criterion Six*: The applying hospital does not meet ranking criterion 1, 2, or 3, is not located in a HPSA, and will use all the additional slots to establish or expand a primary care or general surgery residency program.*

3. Ranking Criterion Seven*: The applying hospital seeks the slots for purposes that do not fit into any of the above ranking criteria.*

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Application Process and CMS Central Office and Regional Office Mailing Addresses for Receiving Increases in FTE Resident Caps

In order for hospitals to be considered for increases in their FTE resident caps, each qualifying hospital must submit a timely application. The following information must be submitted on applications to receive an increase in FTE resident caps:

- The name and Medicare provider number, and Medicare contractor (to which the hospital submits its cost report) of the hospital.
- The total number of requested FTE resident slots for direct GME or IME, or both.
- A completed copy of the CMS Evaluation Form for each residency program for which the hospital intends to use the requested increase in FTE residents.
- Source documentation to support the assertions made by the hospital on the CMS Evaluation Form.
- FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent as-filed cost report. (Include copies of Worksheets E, Part A, E–3, Part IV, *and if a hospital received an increase to its FTE cap(s) under section 422 of the MMA*, a copy of E–3, Part VI).
- An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, of the following information:

"I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil, and administrative action, fines and/or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents."

The completed application and supporting documentation (as described above) must be submitted to the CMS Central Office and the CMS Regional Office for the region in which the applicant hospital is located. The addresses of the CMS Central Office and Regional Offices are listed below.

CMS Central and CMS Regional Office Mailing Addresses for Applications for Increases in FTE Resident Caps

Central Office

Centers for Medicare and Medicaid Services (CMS), Director, Division of Acute Care, 7500 Security Boulevard, Mail Stop C4–08–06, Baltimore, Maryland 21244, (410) 786–4548.

Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region I, JFK Federal Building, Room 23275, Boston, MA 02203, Phone: (617) 565–1331.

Region II (New York, New Jersey, U.S. Virgin Islands, and Puerto Rico)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region II, 26 Federal Plaza, 38th Floor, New York, NY 10278, Phone: (212) 616–2545.

Region III (Delaware, Maryland, Pennsylvania, Virginia and West Virginia, and the District of Columbia)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region III, Public Ledger Building, Suite 216, 150 South Independence Mall West, Philadelphia, PA 19106, Phone: (215) 861–4140.

Region IV (Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region IV, Atlanta Federal Center, 61 Forsyth Street, SW., Suite 4T20, Atlanta, GA 30303–8909, Phone: (404) 562–7300.

Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region V, 233 North Michigan Avenue, Suite 600, Chicago, IL 60601, Phone: (312) 886–6432.

Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region VI, 1301 Young Street, Suite 714, Dallas, TX 75202, Phone: (214) 767–6423.

Region VII (Iowa, Kansas, Missouri, and Nebraska)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region VII, Richard Bolling Federal Building, Room 235, 601 East 12th Street, Kansas City, MO 64106, (816) 564–1843.

Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region VIII, Colorado State Bank Building, 1600 Broadway, Suite 700, Denver, CO 80202, Phone: (303) 844–2111.

Region IX (Arizona, California, Hawaii, and Nevada and Territories of American Samoa, Guam and the Commonwealth of the Northern Mariana Islands)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region IX, 90 7th Street, Suite 5–300 (SW), San Francisco, CA 94103–6708, Phone: (415) 744–3501.

Region X (Alaska, Idaho, Oregon, and Washington)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Financial Management and Fee for Service Operations, Region X, 2201 Sixth Avenue, MS/RX–46, Seattle, WA 98121, Phone: (206) 615–2094.

F. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and to solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In the August 3, 2010 proposed rule (75 FR 46436), we solicited public comments on each of the issues outlined above on the GME and IME provisions discussed in section XVII. Of the proposed rule (now discussed in sections XXI.A. through E. of this final rule) that contained information collection requirements, as discussed below.

Existing regulations at § 413.78 outline the requirements for the determination of the total number of FTE residents in determining direct GME payments to hospitals. Section XVII.B.3. of the preamble of the proposed rule (now section XXI.B.3. of this final rule) discussed the requirement for hospitals that share the costs of resident training in nonprovider settings, as permitted by the Affordable Care Act, to count a proportional share of the time and to record that proportion in a written agreement. We proposed that this proportion must be included on a distinct written agreement even for hospitals that have been paying nonprovider sites concurrently without a written agreement as described in existing regulations. The burden associated with this requirement is the time and effort put forth by the hospital to prepare a written agreement. We estimate it would take one hospital 15 minutes to meet this requirement. Hospitals that already have a written agreement with a nonprovider site may include the proportion on that existing agreement.

In section XVII.B.4. of the preamble of the proposed rule (now section XXI.B.4. of this final rule), we discussed the requirement under the Affordable Care Act for hospitals to maintain records of the amount of time that their residents spend training in nonprovider sites, and to compare that time to the time spent by their residents in nonprovider sites in a base year as the Secretary may specify. We believe that a large part of the information that hospitals would be required to record for the purposes of this provision is contained in rotation schedules, which all hospitals are already required to maintain. Therefore, we do not believe that this requirement poses an undue administrative burden for the purposes of the PRA.

Existing regulations at § 412.105 and § 413.79 outline the requirements for the determination of the number of FTE residents for IME payments to hospitals and the weighted number of FTE residents for direct GME payments to hospitals. In sections XVII.B.4. and 5. of the preamble of the proposed rule (now sections XXI.B.4. and 5. of this final rule), we discussed our proposals that a hospital seeking an adjustment to its FTE resident cap under section 5503 or section 5506 of the Affordable Care Act must provide documentation justifying the adjustment. Sections XVII.D. and E. of the preamble of the proposed rule specified the information that a request would have to include. These requirements are exempt from the PRA in accordance with the provisions of the Affordable Care Act.

We did not receive any public comments on these information collection requirements.

G. Regulatory Impact Analysis

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), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules that have economically significant effects ($100 million or more in any 1 year) or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal government or communities (58 FR 51741).

We have determined that this final rule is not a major rule as defined in 5 U.S.C. 804(2).

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small

governmental jurisdictions. Many hospitals are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (hospitals having revenues of $34.5 million or less in any 1 year). (For details on the latest standards for health care providers, we refer readers to the SBA's Web site at: *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_table.pdf* (refer to the 620000 series).) For purposes of the RFA, we have determined that many hospitals will be considered small entities according to the SBA size standards. Individuals and States are not included in the definition of a small entity. Therefore, the Secretary has determined that this final rule will have a significant impact on a substantial number of small entities. Because we acknowledge that many of the affected entities are small entities, the analyses presented throughout this final rule constitute our regulatory flexibility analysis. In the August 3, 2010 (75 FR 46459 through 46460), we solicited public comments on our estimates and analyses of the impact of the proposed rule on those small entities. We respond to any public comments that we received throughout this final rule.

As discussed in section XXI.D. of this final rule, section 5503 of the Affordable Care Act added a new section 1886(h)(8) to the Act that provides for reductions in the statutory FTE resident caps under Medicare for certain hospitals and authorizes a "redistribution" of the FTE resident slots resulting from the reduction in the FTE resident caps to other hospitals. At this time, we are unable to project how many FTE resident slots will be available for redistribution under section 5503 of the Affordable Care Act. Unlike section 422 of the Medicare Modernization Act, which also provided for a redistribution of FTE resident slots but provided that the redistributed slots will be paid using the national average per resident amount (PRA) for direct GME payment purposes, section 5503 of the Affordable Care Act requires that hospitals be paid for their additional FTE resident slots using the hospitals' specific PRAs. Because we are unable to determine the number of FTE resident slots that will be redistributed under section 5503 of the Affordable Care Act or which hospitals will be receiving additional FTE resident slots, we cannot calculate a direct GME impact for section 5503. We do not know the PRAs and Medicare utilization rates of hospitals that will be receiving additional FTE resident slots. For purposes of determining an impact for IME payment purposes, section 5503 requires us to use an IME multiplier of 1.35; however, we do not know the intern-to-bed ratio and resident-to-bed ratio for the hospitals that will receive additional FTE resident slots or the volume or case mix of Medicare discharges at those hospitals. Therefore, we cannot determine a financial impact for purposes of direct GME and IME for this provision.

In section XXI.B. of this final rule, we discuss our implementation of several changes made by section 5504 of the Affordable Care Act with regard to counting resident time in nonprovider settings for GME and IME payment purposes. Specifically, section 5504 of the Affordable Care Act eliminates the requirement for hospitals to incur "all or substantially all of the costs for the training program in the nonprovider setting," and now hospitals must only incur the costs of the salaries and fringe benefits of residents who train in nonprovider sites. Section 5504 also allows more than one hospital to incur the costs of training programs at nonprovider settings, either directly or through a third party. In addition, section 5504 of the Affordable Care Act creates a recordkeeping requirement for hospitals to track the time residents spend training in nonprovider settings, which CMS must compare to analogous data from a base year.

With respect to the recordkeeping requirement, we are adopting our proposal that rotation schedules be the source for establishing the amount of time that residents spend training in nonprovider sites, both in the base year and in subsequent years. In addition, we are adopting our proposal that cost reporting periods beginning on or after July 1, 2009 and before June 30, 2010 be the base year against which we will compare subsequent years' data to determine if the amount of nonprovider training that occurs in subsequent years increases relative to that base year. We also are adopting our proposal that hospitals only need to maintain records of the unweighted direct GME FTE count of resident training time in nonprovider settings. Finally, we are adopting our proposal to include several additional lines on the Medicare cost report for hospitals to submit these data. Hospitals will be required to report these data on a program-specific basis for their primary care programs, and on an overall hospital basis for their nonprimary care programs. These data will help us to identify whether barriers to resident training in nonprovider sites continue to exist.

We do not believe that any of these policies will have a significant financial impact on the Medicare program. While these policies may allow hospitals to count additional FTEs training in nonprovider sites, we do not believe that this constitutes significant financial impact on the Medicare program, because those residents will have been training at the hospital if they were not training at the nonprovider site. We note that the FTE slot redistribution discussed above that is required by section 5503 of the Affordable Care Act may have an impact on the hospitals' ability to increase the number of residents training at nonprovider sites, unless it moves the training that is currently conducted at the hospital to a nonprovider site. Therefore, the financial impact of section 5504 will be minimal.

In section XXI.C. of this final rule, we discuss our policies to implement the provisions of section 5505 of the Affordable Care Act that make several changes to existing CMS policy with respect to counting resident training time for didactic, scholarly and other activities. Specifically, section 5505(a) of the Affordable Care Act allows a hospital to count the time that residents spend training in an approved program in a "nonprovider setting that is primarily engaged in furnishing patient care" for direct GME purposes. Section 5505(b) of the Affordable Care Act allows nonpatient care activities to count toward resident time for IME purposes as well, but only in certain hospital settings. These nonpatient care activities do not include research activities that are not associated with the treatment or diagnosis or a particular patient. Section 5505 of the Affordable Care Act also allows hospitals to count the time spent by residents on vacation, sick leave, or other approved leave in the hospitals' direct GME and IME resident counts, as long as the leave time does not prolong the total time that the resident is participating in the approved training program. In our discussion of the provisions of section 5505, we described the definitions of the various new terms used in this section of the Affordable Care Act.

We do not believe that any of the policies which implement section 5505 of the Affordable Care Act will have a significant financial impact on the Medicare program. While all of these provisions allow teaching hospitals to claim more resident training time on their respective cost reports, a hospital is limited as to how many resident FTEs it can count. In addition, we note that the FTE slot redistribution that is

required by section 5503 of the Affordable Care Act discussed earlier may impact hospitals' ability to increase the number of residents training at nonprovider sites, unless a hospital moves the training that is currently conducted at the hospital to a nonprovider site. Therefore, the financial impact of section 5505 of the Affordable Care Act is minimal.

In section XXI.E. of this final rule, we discuss our policies to implement section 5506 of the Affordable Care Act. Prior to the passage of the Affordable Care Act, if a teaching hospital closed, its direct GME and IME FTE resident cap slots would be "lost," because those slots were associated with a specific hospital's Medicare provider agreement. Section 5506 of the Affordable Care Act addresses this situation by instructing the Secretary to establish a process by regulation that will redistribute FTE resident cap slots from teaching hospitals that close to hospitals that meet certain criteria.

Section 5506 of the Affordable Care Act applies to teaching hospitals that closed "on or after a date that is 2 years before the date of enactment," that is, March 23, 2008. Accordingly, although section 5506 of the Affordable Care Act does address certain teaching hospital closures that have already occurred, the focus of this provision is primarily on future teaching hospital closures, and ensuring that FTE resident cap slots are not lost to a community. We are unable to project which teaching hospitals will close, how many FTE resident slots they have, and to which hospitals those slots will be ultimately redistributed. Therefore, we cannot determine a financial impact for this provision.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban areas. Thus, we continue to classify these hospitals as urban hospitals. We believe that the changes in this final rule will affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Therefore, the Secretary has determined that this final rule will have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $135 million. This final rule will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications. Because this regulation does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Executive Office of Management and Budget.

XXII. Final Rule: Changes to Whole Hospital and Rural Provider Exceptions to the Physician Self-Referral Prohibition and Related Changes to Provider Agreement Regulations

A. Background

Section 1877 of the Act, also known as the physician self-referral law: (1) Prohibits a physician from making referrals for certain "designated health services" (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies; and (2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for those DHS furnished as a result of a prohibited referral. The Act establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions that pose no risk of program or patient abuse.

Section 1877(d) of the Act sets forth additional exceptions related to ownership or investment interests held by a physician (or an immediate family member of a physician) in an entity that furnishes DHS. Section 1877(d)(1) of the Act provides that an ownership or investment interest in a hospital located in Puerto Rico shall not be considered to be an ownership or investment interest. Section 1877(d)(2) of the Act provides an exception for ownership or investment interests in rural providers. In order for an entity to qualify for the exception, the DHS must be furnished in a rural area (as defined in section 1886(d)(2) of the Act) and substantially all of the DHS furnished by the entity must be furnished to individuals residing in a rural area. Section 1877(d)(3) of the Act provides an exception, known as the "whole hospital" exception, for ownership or investment interests in a hospital located outside of Puerto Rico, provided that the referring physician is authorized to perform services at the hospital and the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital).

B. Changes Made by the Affordable Care Act Relating to the Whole Hospital and Rural Provider Exceptions to Ownership and Investment Prohibition

Section 6001(a) of the Affordable Care Act amended the whole hospital and rural provider exceptions to impose additional restrictions on physician ownership or investment in hospitals to qualify for such exceptions. The statute defines a "physician owner or investor" in a hospital as a physician or an immediate family member of a physician who has a direct or indirect ownership or investment interest in the hospital. In this document, we refer to hospitals with such "physician owners or investors" as "physician-owned hospitals."

Section 6001(a)(2) of the Affordable Care Act provides that in order to satisfy the whole hospital exception, a physician-owned hospital must meet the requirements described in a new section 1877(i)(1) of the Act no later than September 23, 2011. Section 6001(a)(1) of the Affordable Care Act amended the rural provider exception to require that hospitals located in rural areas also satisfy the requirements of new section 1877(i)(1) of the Act no later than September 23, 2011.

Section 6001(a)(3) of the Affordable Care Act, as amended by the HCERA, sets forth the terms of new section 1877(i)(1) of the Act. Under section 1877(i)(1) of the Act, a hospital must:

(1) Have physician owners or investors and a provider agreement in effect on December 31, 2010;

(2) Not expand facility capacity beyond the number of operating rooms, procedure rooms, and beds for which the hospital was licensed as of March 23, 2010, unless an exception is granted by the Secretary;

(3) Comply with certain reporting and disclosure requirements and not condition any physician ownership or investment interests directly or indirectly on a physician making or influencing referrals to or generating other business for the hospital;

(4) Comply with certain requirements designed to ensure that all ownership and investment interests in the hospital are *bona fide*;

(5) Inform patients before admission if the hospital does not have a physician available on the premises during all hours and receive a signed acknowledgment that the patient understands this fact; and

(6) Not have been converted from an ASC on or after March 23, 2010.

In addition, section 1877(i)(2) of the Act requires the Secretary to collect, publish, and update on an annual basis on the CMS Web site (*http://www.cms.hhs.gov*) the physician and other ownership information submitted by hospitals under section 1877(i)(1)(C)(i) of the Act. Section 1877(i)(3) of the Act requires the Secretary to create an exception process related to the prohibition on expansion of facility capacity and publish in the **Federal Register** the final decision with respect to each applicant hospital.

Section 6001(b)(1) of the Affordable Care Act requires the Secretary to establish policies and procedures to ensure compliance with the requirements described in section 1877(i)(1) of the Act, which may include unannounced site reviews of hospitals. Section 6001(b)(2) of the Affordable Care Act requires the Secretary, beginning no later than May 1, 2012, to conduct audits to determine whether hospitals are in compliance with the requirements of new section 1877(i)(1) of the Act.

As noted above, physician-owned hospitals must meet the requirements of new section 1877(i)(1) of the Act not later than 18 months after the date of enactment (that is, by September 23, 2011). We have received numerous inquiries concerning how this language relates to several of the requirements set forth in section 1877(i)(1) of the Act that specify earlier deadlines. We believe that compliance with all requirements must occur no later than September 23, 2011, and failure to satisfy earlier deadlines will preclude use of the revised exceptions after the earlier deadline has passed. For example, section 1877(i)(1)(A) of the Act provides that the hospital must have had physician ownership or investment on December 31, 2010, and a provider agreement in effect on that date. Failure to obtain a provider agreement that is effective on or before December 31, 2010, will preclude use of the revised rural provider and whole hospital exceptions on and after January 1, 2011. Another example can be seen in section 1877(i)(1)(D)(i) of the Act, which provides that the percentage of the total value of physician ownership or investment interests held in the hospital, in the aggregate, must not exceed such percentage as of March 23, 2010. Therefore, if a hospital has no physician ownership or investment as of March 23, 2010, and later adds physician owners or investors, the hospital will not satisfy the whole hospital or rural provider exceptions. Most of the provisions within section 1877(i)(1) of the Act do not specify an explicit deadline for compliance. Thus, in the August 3, 2010 proposed rule (75 FR 46432), we proposed that the deadline for compliance with all provisions within section 1877(i)(1) of the Act that do not contain an explicit deadline is September 23, 2011, that is, 18 months after the date of enactment.

Below, we discuss changes we proposed to make to our regulations in response to section 6001 of the Affordable Care Act, as amended, the public comments we received, if any, our responses to those comments, and our final policies.

C. Changes to Physician Self-Referral Regulations

In order to conform our regulations to the amendments made to the rural provider exception by section 6001(a)(1) of the Affordable Care Act, in the August 3, 2010 proposed rule (75 FR 46432), we proposed to revise § 411.356(c)(1) to specify that, in the case where the rural provider is a hospital, the hospital must meet the requirements of proposed new § 411.362 no later than September 23, 2011.

Similarly, we proposed to revise the whole hospital exception at § 411.356(c)(3) to add a new paragraph (iv) that provides that the hospital must meet the requirements in new § 411.362 not later than September 23, 2011. In the new § 411.362, we set forth the additional requirements for both exceptions as mandated by section 1877(i)(1) of the Act.

1. Physician Ownership and Provider Agreement

Section 1877(i)(1)(A) of the Act requires that, in order to use the rural provider or whole hospital exception under section 1877(d)(3) of the Act, the hospital must have physician ownership or investment on December 31, 2010, and a provider agreement under section 1866 of the Act in effect on this date. In the August 3, 2010 proposed rule (75 FR 46432), we proposed to incorporate these requirements in § 411.362(b)(1) of the regulations.

Section 1877(i)(5) of the Act defines a "physician owner or investor" as a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital. We proposed to incorporate this statutory definition in § 411.362(b)(1) of the regulations.

We received many public comments concerning this proposal and have considered each comment as discussed below.

Comment: Many commenters agreed with the proposed interpretation that, given the language in section 1877(i)(1)(D)(i) of the Act prohibiting the level of physician ownership from increasing after March 23, 2010, both existing hospitals and prospective hospitals, must have physician ownership or investment on March 23, 2010 regardless of the provision in section 1877(i)(1)(A) of the Act, which states that a hospital must have physician ownership on or before December 31, 2010 and a provider agreement in effect on such date. The commenters asserted that this provides a bright line rule and assures that existing hospitals and hospitals currently under development are treated equally with respect to physician ownership and investment.

Response: We appreciate the commenters' support for our proposals.

Comment: Two commenters disagreed with our interpretation that both existing hospitals and prospective hospitals must have physician ownership or investment on March 23, 2010 regardless of the provision in section 1877(i)(1)(A) of the Act stating that a hospital must have physician ownership on December 31, 2010. One commenter believed that our interpretation of the statute is flawed because it is contrary to congressional intent and the principle of statutory construction providing that, wherever possible, a statute should be construed to give effect to every word and to avoid rendering language meaningless. The commenter reasoned that, in the case of a hospital under development, there is merely a construction project, rather than a licensed hospital, in existence as of March 23, 2010. The commenter indicated that our proposed interpretation requiring physician ownership to exist on March 23, 2010, would render meaningless the statutory language specifying that a hospital must have physician ownership on December 31, 2010. Both commenters asserted that the March 23, 2010 date was a drafting

error that should be corrected through rulemaking. The commenters urged CMS to reconcile these provisions by applying the March 23, 2010 deadline for measuring the baseline percentage of physician ownership only to hospitals that already had a Medicare provider agreement in effect on March 23, 2010 and allowing hospitals that are under development and without any existing physician ownership or investment interests as of March 23, 2010 to add physician owners until the end of the year.

Response: We disagree with the commenters' proposal and reasoning. First, section 1877(i)(1)(D)(i) of the Act specifically states that the percentage of the total value of physician ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, must not exceed such percentage as of date of enactment (March 23, 2010). Nothing in the plain language of the statute suggests that this provision applies only to hospitals that already have a provider agreement in effect on March 23, 2010. The reference to entities whose assets include the hospital suggest that Congress intended this provision to apply to hospitals that are under development. Therefore, if a hospital does not have physician ownership on March 23, 2010, and later adds physician owners, the hospital will be unable to qualify for the rural provider or whole hospital exception. Adopting the commenter's suggested interpretation would render section 1877(i)(1)(D)(i) of the Act entirely meaningless and require us to substitute its reference to the date of enactment (March 23, 2010) with "December 31, 2010." This is contrary to the principle that a statute must not be construed to add words that Congress has not included.

Second, the interpretation in the proposed rule does not render any provision of the Act meaningless. Our interpretation gives meaning to both sections 1877(i)(1)(A) and 1877(i)(1)(D)(i) of the Act. Reading both of these statutory provisions together, a hospital must have at least some physician ownership on March 23, 2010 and, even if it subsequently decreases physician ownership, it must at least retain some physician ownership on December 31, 2010. The hospital may not, for example, reduce physician ownership to zero on December 31, 2010, and later increase physician ownership to the level that existed on March 23, 2010. Additionally, we are clarifying that a physician-owned hospital may add or increase the number of physician owners or investors, or replace physician owners or investors, as long as the aggregate percentage of physician ownership or investment does not increase.

Comment: One commenter requested clarification regarding whether a physician-owned hospital would satisfy the exception if its provider agreement is issued after December 31, 2010, but with an effective date on or before December 31, 2010. The commenter suggested that the proposed regulatory language of § 411.362(b)(1) should be revised to read " * * * a provider agreement under section 1866 of the Act in effect on that date." Additionally, the commenter suggested that proposed § 411.362(b)(2) be revised to include similar language clarifying an effective date of December 31, 2010.

Response: A physician-owned hospital would satisfy the whole hospital or rural provider exception if its provider agreement is issued after December 31, 2010, so long as the provider agreement letter contains an effective date of on or before December 31, 2010.

Comment: One commenter stated that it takes a tremendous amount of money, time, staff and other resources to develop a hospital, obtain financing, and complete other steps necessary to have a provider agreement in effect on December 31, 2010 deadline to be grandfathered. The commenter further stated that it entered into a formal physician contribution agreement on March 1, 2010, and closed the contribution on April 30, 2010, relying on the language of section 6001 of the Affordable Care Act, believing it had until December 31, 2010 to obtain a Medicare provider agreement and physician ownership. The commenter contended that under CMS' interpretation of section 6001 of the Affordable Care Act and the March 23, 2010 enactment date, this hospital will not qualify for the whole hospital exception if it adds any physician owners after that date. The commenter further asserted that this interpretation is inconsistent with statutory construction and has harsh consequences. The commenter stated that if it had known March 23, 2010 was the deadline, it would have conformed to that date.

Response: The existence of the proposed legislation was well known and publicized. The terms of the legislation as enacted on March 23, 2010, clearly provided that the percentage of the total value of physician ownership or investment interests held in the hospital, in the aggregate, must not increase above the level that existed on the date of enactment. The commenter's choice to proceed with the contribution and not close it sooner was extremely risky under the circumstances if it intended for the physician owners to be able to refer to the new hospital. As noted above, we disagree that our interpretation of the statute is impermissible.

Comment: One commenter contended that interpreting section 6001 of the Affordable Care Act to require physician ownership in the hospital by March 23, 2010, renders meaningless the requirement that a physician-owned hospital must not have been converted from an ambulatory surgical center (ASC) to a hospital on or after the date of enactment.

Response: We disagree. Section 1877(i)(1)(D)(i) provides that the total value of the ownership or investment interests held by physicians in the aggregate in the hospital "or in an entity whose assets include the hospital" cannot exceed the percentage that existed on March 23, 2010. We believe that, depending on the facts, an ASC that later converts to a hospital could be an "entity whose assets include the hospital." In our experience, the hospital that exists after conversion from an ASC possesses the same equipment and other assets that once belonged to the ASC. For example, if an ASC converted to a physician-owned hospital on April 1, 2010, and the hospital later has a provider agreement in effect on December 31, 2010, it might not qualify for the whole hospital or rural provider exception. The parties could seek an advisory opinion to address this issue.

Comment: Another commenter raised a similar objection, asserting that there was an inconsistency between CMS' proposed interpretation that the hospital must have physician ownership by March 23, 2010, but that the facility expansion deadline is December 31, 2010, not March 23, 2010. The commenter believed these distinctions are arbitrary and that CMS is fabricating Congressional intent by stating in the proposed rule (75 FR 46434) that section 1877(i)(1)(D)(i) of the Act "assumes the existence of physician ownership" on March 23, 2010.

Response: We recognize that some commenters disagree with our interpretations of the statutory requirements. However, we believe that, in each instance, we have interpreted the various sections harmoniously. Also, we must clarify that we did not propose a uniform December 31, 2010 facility expansion deadline. Rather, consistent with the statute, we proposed in § 411.362(b)(2) that the hospital may not increase the number of operating

rooms, procedure rooms, and beds beyond that for which the hospital is licensed on March 23, 2010 (or, in the case of a hospital that did not have a provider agreement, in effect as of that date, but does have a provider agreement in effect on December 31, 2010, the effective date of such provider agreement).

Comment: One commenter asserted that many hospitals have projects that have been in the works prior to March 23, 2010, and December 31, 2010 is not enough time to obtain all approvals, licenses, and inspections in order to qualify for the grandfather provision. The commenter stated that, because the provider agreement deadline is this year, some hospitals will be disadvantaged merely because complying with regulations in some States takes longer than others.

Response: Section 1877(i)(1)(A) of the Act requires that, in order to use the whole hospital or rural provider exception, the hospital must have a provider agreement in effect on December 31, 2010. This is a statutory directive and we do not have the discretion to address the concern raised by the commenter.

Comment: One commenter recommended that CMS adopt, for the purposes of section 1877(i)(1)(A)(ii) of the Act only, the concept of an "approvable" application, similar to what is done for physicians. The commenter further suggested that assuming the applicant is ultimately successful in its certification survey, the point at which the application is submitted and reviewed by the fiscal intermediary or MAC and recommended to CMS for approval would be an appropriate point to establish compliance with the provider agreement deadline. An alternative suggestion made by the commenter was to require any fiscal intermediary or MAC that receives a provider application from a hospital trying to comply with section 1877(i)(1)(A)(ii) of the Act to review and respond to the applicant within 15 days.

Response: We are not persuaded by the commenter's recommendations. We will consider a provider to have a provider agreement in effect on December 31, 2010, if the effective date of the agreement is no later than December 31, 2010. As set forth in § 489.13(b), the effective date of a provider agreement may not be earlier than the latest of the dates on which CMS determines that the applicable Federal requirements are satisfied.

After consideration of the public comments we received, we are adopting as final, without modification, our proposed regulations at § 411.362(b)(1) and § 411.362(a)(1).

2. Limitation on Expansion of Facility Capacity

Section 1877(i)(1)(B) of the Act requires that the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after March 23, 2010, be no greater than the number of operating rooms, procedure rooms, and beds for which the hospital was licensed on that date. However, section 1877(i)(3)(C) of the Act authorizes the Secretary to permit a physician-owned hospital to increase capacity above its "baseline number of operating rooms, procedure rooms, and beds." Section 1877(i)(3)(C)(iii) of the Act, as amended by section 1106(2)(B) of the HCERA, defines the term "baseline number of operating rooms, procedure rooms, and beds" to mean "the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed as of [March 23, 2010] (or, in the case of a hospital that did not have a provider agreement in effect as of that date, but does have an agreement in effect on December 31, 2010, the effective date of such provider agreement)." Although section 1877(i)(1)(B) of the Act does not reflect the language in section 1877(i)(3)(C)(iii) permitting the baseline facility capacity to be determined for some hospitals as of December 31, 2010, we must read sections 1877(i)(1)(B) and 1877(i)(3)(C)(iii) of the Act together and interpret them harmoniously. Accordingly, in proposed § 411.362(b)(2) in the August 3, 2010 proposed rule (75 FR 46463), we specified that the hospital will be limited to the number of operating rooms, procedure rooms, and beds for which the hospital is licensed on March 23, 2010, or if the hospital did not have a provider agreement in effect as of that date, but does have an agreement in effect on December 31, 2010, the effective date of such provider agreement.

The limitation on expansion of facility capacity applies to operating rooms, procedure rooms, and beds for which the hospital is licensed. It is important to note that the limitation on expansion applies to operating rooms and procedure rooms, regardless of whether a State licenses these rooms. Referrals are prohibited if made by physician owners and investors after facility expansion and prior to the Secretary's granting of an exception to the capacity restriction. Exceptions for expanding facility capacity will protect only those referrals made after the exception is granted.

Section 1877(i)(3)(G) of the Act specifies that "the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed)." Under our proposed definition of procedure rooms at § 411.362(a)(2), the term is limited to the types of rooms specified in the statute. Although the statute would permit us to define "procedure rooms" to include rooms where other services are performed, we did not propose to do so. We encouraged public comments on whether "procedure rooms" should include rooms where additional services, such as CT or PET scans, or other services, are performed.

Section 1877(i)(3)(A) of the Act gives the Secretary until January 1, 2012, to promulgate regulations concerning the process for a hospital to apply for an exception and provides that the implementation of this process must occur on February 1, 2012. As we indicated in the proposed rule, we plan to issue a separate rulemaking document that will provide for implementation of this exceptions process.

We received a large number of comments on our proposal and have considered each comment as discussed below. Commenters in favor of our proposal agreed that the limitations on expansion on procedure rooms, operating rooms, and beds were necessary and consistent with section 1877(i)(1)(B) of the Act. Commenters who opposed the proposal raised questions concerning the financial impact upon hospitals that were in the midst of an expansion, our interpretation of the expansion deadline, and the interplay with the deadlines associated with other provisions found in section 1877(i) of the Act. A large number of commenters requested clarifications regarding situations where the State does not license these rooms and beds. We discuss below all of the significant points raised by commenters to our proposal.

Comment: One commenter urged CMS to confirm that a physician-owned hospital may replace operating rooms, procedure rooms, and beds with new ones, so long as the total number of each does not increase beyond the baseline number for which the hospital is licensed as of March 23, 2010. The

commenter noted that while Congress significantly increased the requirements to satisfy the whole hospital exception, such hospitals are permitted to exist under the law and, therefore, will need to be improved to maintain their infrastructure over time.

Response: The commenter correctly characterizes our interpretation of the Act. The language in section 1877(i)(1)(D) of the Act limits expansion of the total number of operating rooms, procedure rooms, and beds beyond the number for which the hospital is licensed as of March 23, 2010. Thus, if a hospital retires old beds for new beds (or retires old operating rooms and procedure rooms for new operating rooms and procedure rooms) without increasing the baseline number, there would be no violation of section 1877(i)(1)(B) of the Act.

Comment: One commenter stated that the proposed regulation did not address hospitals that had a provider agreement in effect on March 23, 2010, and were in the middle of an expansion project, including those projects or renovations that were occurring in States that do not license operating or procedure rooms.

Response: We recognize that States usually do not license the number of hospital operating and procedure rooms. As we stated in the August 3, 2010 proposed rule (75 FR 46433), the limitation on expansion applies to operating rooms and procedure rooms, regardless of whether a State licenses these rooms. We interpret the statutory phrase "for which the hospital is licensed" as applying only to beds. In other words, we believe the statute limits a hospital's ability to increase the number of beds for which it was licensed and the number of operating and procedure rooms that existed at the hospital and were operational on March 23, 2010 (or December 31, 2010, if applicable). A hospital that had a provider agreement in effect on March 23, 2010 and was in the process of expanding the number operating rooms or procedure rooms, but did not have the rooms in existence by March 23, 2010, would not be able to include in its baseline facility capacity the rooms that were not yet operational. The hospital could, however, seek the Secretary's approval of the expansion through the process that will be established under section 1877(i)(3)(A) of the Act.

Comment: One commenter stated that it could be difficult to satisfy the criteria for obtaining the Secretary's approval for an exception to the prohibition against expansion of facility capacity, particularly for general acute care full service hospitals, within an area of population growth.

Response: We understand the concerns expressed by the commenter, but we have no discretion to ignore the standards set forth in sections 1877(i)(3)(E) and (i)(3)(F) of the Act.

Comment: Several commenters objected to the proposed interpretation of section 1877(i)(1)(B) of the Act that the hospital will be limited to the number of operating rooms, procedure rooms, and beds for which the hospital is licensed on March 23, 2010, or in the case of a hospital that did not have a provider agreement in effect on that date, but does have an agreement in effect on December 31, 2010, the effective date of such agreement. Some commenters objected based on equity, while other commenters made arguments concerning this interpretation of section 1877(i)(1)(B) of the Act. Those commenters who objected to the interpretation suggested that the last clause in subsection (B) refers not the "date of enactment," which Congress could have easily done, but rather to "such date" as the date by which expansion must be completed. The commenters asserted that this language could refer to either the date of enactment or December 31, 2010, which appears in the preceding provision at section 1877(i)(1)(B) of the Act. The commenters further stated that this provision is ambiguous and capable of being interpreted several ways that do not necessitate limiting the number of beds, operating rooms, or procedure rooms to March 23, 2010 numbers. Additionally, some of the commenters asserted that this proposal renders the provision "18 months after the date of enactment" meaningless and superfluous. Those commenters stated that the statute should be read to give meaning to the 18-month deadline so that the hospital can add beds, operating rooms, or procedure rooms to its license before 18 months after the date of enactment.

Response: We are not persuaded to adopt either of the expansion deadlines recommended by the commenters. Although there may be varying interpretations of the statutory language, we believe that our reading is a rational reading of the statute. Section 1877(i)(1)(B) of the Act requires that the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after the date of enactment (March 23, 2010), be no greater than the number of operating rooms, procedure rooms, and beds for which the hospital was licensed "as of such date." We do not believe the commenter's suggestion that we construe "such date" to mean any date other than the date of enactment is reasonable. We note that section 1877(i)(3)(C) of the Act authorizes the Secretary to permit a physician-owned hospital to increase capacity above its "baseline number of operating rooms, procedure rooms, and beds." Section 1877(i)(3)(C)(iii) of the Act, as amended by section 1106(2)(B) of the HCERA, defines the term "baseline number of operating rooms, procedure rooms, and beds" to mean "the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of [March 23, 2010] (or, in the case of a hospital that did not have a provider agreement in effect as of that date, but does have an agreement in effect on December 31, 2010, the effective date of such provider agreement)." Although section 1877(i)(1)(B) of the Act does not reflect the language in section 1877(i)(3(C)(iii) of the Act permitting the baseline facility capacity to be determined for some hospitals as of December 31, 2010, we must read sections 1877(i)(1)(B) and 1877(i)(3)(C)(iii) of the Act together and interpret them harmoniously. Accordingly, in proposed § 411.362(b)(2), we specified that the hospital will be limited to the number of operating rooms, procedure rooms, and beds for which the hospital is licensed on March 23, 2010, or if the hospital did not have a provider agreement in effect as of that date, but does have an agreement in effect on December 31, 2010, the effective date of such provider agreement. Referrals are prohibited if made by physician owners and investors after facility expansion and prior to the Secretary's granting of an exception to the capacity restriction. Exceptions for expanding facility capacity will protect only those referrals made after the exception is granted.

The other recommendation made by commenters involved interpreting the statute to permit facility expansion until September 23, 2011. In the August 3, 2010 proposed rule (75 FR 46432), we stated that physician-owned hospital must meet the requirements of new section 1877(i)(1) of the Act not later than 18 months after the date of enactment (that is, by September 23, 2011). We believe that compliance with all requirements must occur no later than September 23, 2011, and failure to satisfy earlier deadlines (such as that forth in section 1877(i)(1)(B) of the Act) will preclude use of the revised exceptions after the earlier deadlines have passed. We do not believe that the commenters' suggestion gives effect to other deadlines in the statute.

Comment: One commenter asserted that the deadline for obtaining physician ownership and a provider agreement and the deadline for measuring the baseline facility capacity are in conflict. The commenter believed there was a drafting oversight and that the proposed rule defies logic. The commenter remarked that the "grandfathering" of providers and the limitations on expansion were clearly intended to run until the end of this year but because of a technical oversight, the grandfathered provider must have physician ownership as of March 23, 2010.

Response: We are obligated to follow the statutory directive, and we believe our interpretation of the statutory provision is reasonable. We believe there is no conflict between section 1877(i)(1)(A) of the Act, which mandates that, in order to use the rural provider and whole hospital exceptions, the hospital must have a provider agreement and physician ownership or investment on December 31, 2010, and the restriction on facility expansion set forth in section 1877(i)(1)(B) of the Act and interpreted in accordance with section 1877(i)(3)(C) of the Act. As we noted in the proposed rule, several of the requirements in section 1877(i)(1) of the Act have differing deadlines for compliance and we must give meaning to those deadlines.

Comment: One commenter argued that the proposed rule will have a significant and deleterious effect on psychiatric hospitals in particular because the number of beds available for psychiatric patients has been declining over the years and as a result, this shortage has increased demands on hospital emergency rooms. The commenter recommended the following changes to the proposed rule at § 411.362(b)(2):

1. Exempt grandfathered psychiatric hospitals from § 411.362(b)(2).

2. Revise the rule to specify that grandfathered psychiatric hospitals are permitted to expand bed capacity (only) beyond that for which it was licensed as of March 23, 2010.

Response: We are not persuaded to adopt the commenter's suggestions. We have the authority pursuant to section 1877(b)(4) of the Act to create new regulatory exceptions for financial relationships such as the one recommended by the commenter, provided that such an exception poses no risk of program or patient abuse. At this time, we are unable to conclude that there is no risk of program or patient abuse and, therefore, we will not be promulgating the exception requested by the commenter. We will continue to consider whether there are certain types or categories of hospitals that warrant an exception. In addition, we remind the commenter that, pursuant to section 1877(i)(3)(A) of the Act, there will be a process for hospitals to apply for an exception to the limitation on the expansion of rooms and beds. Individual psychiatric hospitals that are impacted by the limitation on expansion may wish to request an exception under this process.

Comment: One commenter stated the prohibition against facility expansion should not apply when a physician-owned hospital relocates some or all of the operating rooms, procedure rooms, or beds for which the hospital was licensed as of March 23, 2010, to an existing or new site if:

1. Relocation would not increase the number of operating rooms, procedure rooms, or beds for which the hospital was licensed on March 23, 2010;

2. Following this relocation, all of the hospital's operating rooms, procedure rooms, and beds (including those relocated to the other site) would continue to be operated by the same legal entity, under the same State-issued hospital license, the same Medicare provider agreement and the same CMS certification number;

3. The hospital's original location and other site would be operated in compliance with all applicable Medicare laws and requirements; and

4. The hospital would comply fully with all the requirements under the whole hospital exception.

The commenter urged CMS to clarify that a hospital is free to relocate its existing beds under the circumstances described above.

Response: Under the circumstances described by the commenter, the relocation of beds would not constitute an increase in the number of licensed beds. Under other circumstances, the hospital may wish to seek an advisory opinion regarding the applicability of the prohibition against expansion.

Comment: One commenter contended that section 1877(i)(1)(B) of the Act does not provide any basis for including restrictions on how a hospital uses its beds, as long as it does not increase the number of beds beyond the number that were licensed on March 23, 2010. Another commenter similarly inquired whether operating rooms, procedure rooms, and beds could change purposes (for example, through the conversion of a cardiac catheterization room into an endoscopy room), as long as the number of operating rooms, procedure rooms, and beds in the aggregate did not increase. However, another commenter asserted that, under the terms of the statute, a hospital cannot reduce its operating rooms to increase the number of its procedure rooms, and each individual category must remain capped at its March 23, 2010 level.

Response: We interpret section 1877(i)(1)(B) of the Act to impose restrictions only on the aggregate number of operating rooms, procedure rooms, and beds. Therefore, we will not impose any restrictions regarding the manner in which a physician-owned hospital uses its beds, operating rooms, or procedure rooms. In other words, if a hospital is authorized to operate 20 beds, 2 operating rooms, and 2 procedure rooms, the hospital may reduce or increase the number of beds, operating rooms, or procedure rooms as long as the resulting aggregate number of beds, operating rooms, and procedure rooms does not exceed 24 (assuming any applicable licensure requirements are satisfied).

Comment: Several commenters supported the statement in the preamble of the proposed rule (75 FR 46433) that the limitation on the expansion of procedure rooms and operating rooms applies regardless of whether a State licenses those rooms.

Response: We appreciate the commenters' support for our position.

Comment: One commenter recommended that CMS clarify that even if the hospital's State-issued license does not separately enumerate the number of operating rooms or procedure rooms, the State can confirm the number of operating rooms and procedure rooms that the hospital was authorized to operate as of March 23, 2010, and if no increase has occurred since that time, the hospital would be viewed as being compliant with this provision.

Response: The commenter's suggestion is an acceptable method of demonstrating compliance with section 1877(i)(1)(B) of the Act.

Comment: One commenter requested that the proposed regulation be revised to clarify how the number of operating rooms and procedures rooms at physician-owned hospitals will be determined in States that do not license such rooms. The commenter recommended that CMS adopt certain conditions which, if met, would deem an operating room or procedure room to be "licensed." The commenter stated that if a hospital was conducting a construction or renovation project as of March 23, 2010, in a State that does not license operating rooms or procedure rooms, that room should be deemed licensed as of March 23, 2010.

Response: We are not persuaded to adopt the commenter's suggestion to

revise our proposal such that a renovation or construction project that was underway as of March 23, 2010, would be deemed licensed. As stated above, we do not interpret the statutory reference to licensure as applying to operating and procedure rooms. We believe the baseline capacity includes those operating and procedure rooms that were in existence and operational on March 23, 2010 (or December 31, 2010, if applicable). The advisory opinion process could be used to determine whether rooms undergoing renovation or construction were in existence by the applicable date.

Comment: One commenter urged CMS to clarify whether a prohibited expansion would occur if a hospital has rooms "approved" by the State in "shelled space," which is space included in plans for a future specified use, if the space has been physically built (walls, floors, doors) on or before the baseline date determined under subparagraph (3)(C)(iii) of section 1877(i) of the Act but fitted out after the baseline date.

Response: We are unclear as to the situation that the commenter is describing. The commenter's situation may be addressed through the advisory opinion process or the process for obtaining an exception to the prohibition on facility expansion.

Comment: The majority of commenters agreed with the proposed definition of "procedure rooms." Many commenters stated that the statute makes specific references to these services, underscoring Congress' intent to ensure that this definition specifically mirrors that statutory language. Another commenter stated that to expand the listing of specific procedure rooms would not take into account continued trends in technological advancements of equipment that require hospitals to change the traditional and treatment option to modalities that are less invasive. This same commenter asserted that restricting hospitals' ability to add these services for their patients would fragment treatment plans for the patients, thus requiring transfers to other facilities, which may result in additional costs to the patients and providers.

Response: We agree with many of the points offered by the commenters. Therefore, we are not adding any additional services to the proposed definition of procedure rooms beyond those set forth in section 1877(i)(3)(G) of the Act.

Comment: One commenter recommended that the regulatory definition of "procedure rooms" be broadened in a number of respects:

1. The definition should include rooms where the following additional services are provided: Radiation therapy and all diagnostic imaging services, including MRI, CT, and PET scans, interventional radiology, and mammography.

2. The definition should include freestanding emergency departments, prohibiting physician-owned hospitals from adding these facilities after the date of enactment of the Affordable Care Act.

3. The definition should include areas not technically defined as separate procedure rooms, in which medical services similar to those provided in procedure rooms can be provided, and the commenter believes that the proposed rules should account for changes in technology which may allow the list of procedures to be furnished in a patient room.

Response: We are not persuaded that a broadening of the definition of procedure rooms is warranted at this time. However, we will continue to monitor expansions in procedure rooms to determine whether we should revisit this issue in future rulemaking, such as the separate rulemaking that will provide for implementation of the exceptions process.

Comment: Several commenters noted that the proposed rule did not address the process for requesting exceptions to the growth restriction on existing physician-owned hospitals. The commenters stated that more guidance is necessary for hospitals to align their actions with section 6001 of the Affordable Care Act.

Response: We understand the commenters' request for more guidance, particularly with regards to the exception process. However, section 1877(i)(3)(A) of the Act gives the Secretary until January 1, 2012 to promulgate regulations concerning the exceptions process. We believe it is important that we balance the commenters' sense of urgency with the need to develop and implement an exceptions process that adheres to the statute, addresses all issues necessary for a provider to request such an exception, and ensure that we receive all information needed in order to timely render an informed decision.

After consideration of the public comments we received, we are finalizing our proposed § 411.362(b)(2) without modification.

3. Preventing Conflicts of Interest

Section 1877(i)(1)(C)(i) of the Act requires the hospital to submit to the Secretary an annual report containing a detailed description of the identity of each physician owner or investor and any other owners or investors of the hospital, and the nature and extent of all ownership and investment interests in the hospital. We plan to propose procedures for this reporting requirement in a separate rulemaking or guidance document.

Sections 1877(i)(1)(C)(ii) through (i)(1)(C)(iv) of the Act requires hospitals to: (1) Develop procedures requiring a referring physician owner or investor to disclose (in time to permit the patient to make a meaningful decision about receipt of care) his or her ownership interest to the patient and, if applicable, the treating physician's ownership or investment interest; (2) not condition any physician ownership or investment interests either directly or indirectly on the physician making or influencing referrals to the hospital or otherwise generating business for the hospital; and (3) disclose on any public Web site for the hospital and in any public advertising that it is owned or invested in by physicians. Compliance with these three requirements must be achieved no later than September 23, 2011.

To incorporate these requirements into our regulations, in the August 3, 2010 proposed rule (75 FR 46463), we proposed to: (1) Add § 411.362(b)(3)(ii)(A) to specify that a hospital must require each referring physician owner or investor to agree, as a condition of continued medical staff membership or admitting privileges, to provide written disclosure of his or her ownership or investment interest in the hospital (and, if applicable, the treating physician's ownership or investment interest in the hospital) to all patients the physician refers to the hospital, at the time the referral is made; (2) add § 411.362(b)(3)(ii)(B) to specify that a hospital may not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital; and (3) add § 411.362(b)(3)(ii)(C) to specify that the hospital must disclose on any public Web site for the hospital and in any public advertising that the hospital is owned or invested in by physicians.

Proposed § 411.362(b)(3)(ii)(A) defines the procedures that a hospital must have in place to require its physician owners and investors to make certain patient disclosures. In the proposed rule, we stated that we do not believe the disclosures to be made by physicians will be burdensome. For example, a physician owner or investor could provide a written, form notice to each patient that discloses the

physician's ownership or investment interest in the hospital, informs the patient that his or her treating physician may have an ownership or investment interest in the hospital, and directs the patient to review an attached list identifying all other physician owners or investors in the hospital. This notice may be used by the patient to make a meaningful decision regarding his or her receipt of care.

In the August 3, 2010 proposed rule, we solicited public comments on several different issues relating to preventing conflicts of interest. First, we sought public comments on the benefits and drawbacks of our proposal, discussed above, relating to the procedures hospitals must have in place to require referring physician owners and investors to make the patient disclosures set forth in section 1877(i)(1)(C)(ii) of the Act. We stated that we were interested in receiving information about other methods and alternative approaches to address this issue and what should constitute sufficient hospital procedures to require such disclosures to a patient by a referring physician owner or investor.

Second, we indicated that we were aware that a patient may have multiple conditions for which there are a variety of physician specialists who are responsible for different aspects of a patient's care, even though the statute refers to a single "treating physician." We did not propose to define "treating physician." We stated that we would consider treating physicians to be those physicians who are responsible for any aspect of a patient's care or treatment. We welcomed public comments on this approach.

Finally, we encouraged public comments on the methods a hospital should be required to use in disclosing its physician ownership or investment in public advertising pursuant to section 1877(i)(1)(C)(iv) of the Act. For example, we indicated that we were interested in comments on whether a hospital should be required to disclose physician ownership or investment on its homepage, any particular page on its Web site (for example, an "About Us" page), or all pages on its Web site; the types of media that constitute, or do not constitute, public advertising; and whether a minimum font size should be required for the disclosure.

We received several comments on this proposal and have considered each comment as discussed below. Commenters in favor of our proposal agreed that the proposed procedures for assuring that patients are informed about hospital ownership interests of referring and treating physicians are adequate, reasonable, and not overly burdensome. The commenters who were opposed to the proposal raised various issues concerning the appropriateness and timeliness of ownership disclosure to patients by hospitals and physicians. Commenters also had suggestions concerning the methods hospitals should utilize in disclosing physician ownership on Web sites and in public advertising.

Comment: Several commenters noted that the proposed rule did not address the requirement under section 1877(i)(1)(C)(i) of the Act for hospitals to submit to the Secretary an annual report containing a detailed description of the identity of each physician and other owner or investor in the hospital and the nature and extent of all ownership and investment interests in the hospital. The commenters stated that more guidance is necessary for hospitals to ensure compliance with this provision by September 23, 2011.

Response: We understand the commenters' request for more guidance regarding the process for reporting information to CMS. As noted above, the process for collecting this information will be the subject of a separate rulemaking or guidance document. We are using this time to determine the exact type of information that must be reported, the mechanisms for hospitals to submit the required information, instructions to hospitals, and how we will post the required information on the CMS Web site. After the process has been determined, we will provide hospitals and physicians with the guidance requested by the commenters. In the meantime, we have added a provision at § 411.362(b)(3)(i) to clarify that the hospital shall submit the annual report at such time and in such manner as specified by CMS.

Comment: A few commenters had questions about the appropriateness and timeliness of ownership disclosures made by physicians to their patients. For instance, one commenter wanted to know: (1) If a separate disclosure is required for every admission; (2) when should a disclosure occur; (3) if a physician has previously disclosed ownership, whether another disclosure should occur before admission; (4) if a patient is treated in an outpatient clinic, but suddenly needs to be admitted as an inpatient, should disclosure be immediate or after treatment; and (5) if disclosures are required for confused, unconscious, or otherwise incoherent patients. Another commenter suggested that it will be problematic to require in all cases a referring physician to disclose to the patient his or her ownership interest in a timely fashion to permit the patient to make a meaningful decision about receipt of care.

Response: Section 1877(i)(1)(C)(ii) of the Act requires that a physician disclose his or her ownership interest in a hospital to a referred patient by a time that permits the patient to make a "meaningful decision regarding the receipt of care." We stated in the proposed rule that, in order for the patient to make a meaningful decision regarding the receipt of care, the disclosure must occur at the time of referral. We have reconsidered this policy in light of the commenters' concerns regarding the burden of making disclosures at the time of each referral and the potential for this policy to result in disproportional overpayment liability under section 1877(g)(1) of the Act. We are modifying the regulation text to mirror the statutory language, which we believe offers more flexibility regarding the timing and method of disclosure. We recognize that our existing regulations governing provider agreements at § 489.20(u)(2) require each physician who is a member of the hospital's medical staff to agree to make a similar disclosure at the time of referral. Because we did not propose to change this standard in § 489.20(u)(2), we are not doing so in this final rule.

Comment: One commenter believed that CMS should give further consideration as to how it can impose the disclosure requirements directly on the physician rather than the hospital. The commenter noted that the hospital, not the physician, is in a position to be sanctioned for a physician owner's failure to disclose. Another commenter recommended that the loss of a physician's medical staff membership or admitting privileges was too draconian a remedy for the physician's failure to disclose his or her hospital ownership interests. One commenter recommended that if a physician does not disclose his or her ownership in a hospital at the time of referral, the physician should not receive Medicare payment for his or her professional services provided at the hospital.

Response: Section 1877(i)(1)(C)(ii) of the Act requires hospitals to have procedures in place to require a referring physician owner to disclose to the patient his or her ownership or investment interest in the hospital as well as any ownership interest, if applicable, of the treating physician. Those procedures, in turn, must require physicians to agree to make such disclosures as a condition of continued medical staff membership or admitting privileges. A physician's failure to fully comply with such agreement is a

disciplinary matter for the hospital to resolve in accordance with the medical staff bylaws and would not necessarily result in a violation of the physician self-referral law. As noted above, a similar requirement already appears in our provider agreement regulations at § 489.20(u)(2). The last comment is beyond the scope of this rulemaking.

Comment: One commenter suggested that, in emergency situations, that is, non-elective admissions, it will be very difficult for physicians to provide the required disclosure in a timely fashion. Therefore, the commenter recommended that when a patient is first seen by a physician in a hospital emergency department, the physician should be exempted from the pre-admission disclosure requirement. Another commenter suggested that the physician ownership disclosure requirement can be satisfied by the hospital on behalf of the physician during the patient admission and registration process, as hospitals are already required, under § 489.20(u)(1) to disclose physician ownership at the beginning of the patient's hospital stay or outpatient visit.

Response: In the case of a patient who is treated by a physician owner in the hospital emergency department, we believe that no disclosure is necessary other than that required under § 489.20(u). The statute requires hospitals to ensure that physician owners make the relevant disclosures "by a time that permits the patient to make a meaningful decision regarding the receipt of care." By the time a patient has presented at the emergency department, the patient or the patient's representative has already made a decision about where to receive care. If a patient is admitted to the hospital, the patient or the patient's representative must be notified by the hospital under § 489.20(u) that the hospital is physician-owned.

Comment: One commenter believed that the regulations should be amended to allow physicians to prominently display in their offices a notice informing patients that the physician has an ownership interest in a particular hospital facility and that the patient can inquire further or request admission to another facility. Another commenter noted our suggestion that the referring physician could disclose the ownership or investment interest of any treating physician by directing the patient to review a list of other investors in the hospital. The commenter requested clarification as to whether physician owners would be required to provide such a list for each patient referral. The commenter suggested that if this requirement were imposed for each and every referral, the paperwork involved would be substantial and cumbersome. The commenter recommended that such a disclosure be required only when a patient requests a list of all other owners.

Response: We are not revising the regulations to require any particular means of notification by a physician of hospital ownership. Physicians can inform patients of their ownership interests and the ownership interests of treating physicians in any manner that permits the patient to make a meaningful decision regarding the receipt of care. A prominently displayed sign and list of other treating physicians with an ownership or investment interest in the hospital could satisfy the disclosure requirement, although we note that it may not be a meaningful disclosure in all cases. If a patient is blind, unable to read, or is incapacitated, it would be incumbent upon the physician to notify the patient or an immediate family member of the patient in a manner other than the one suggested.

Comment: One commenter noted that, in many cases, a patient of a referring physician with hospital ownership interests may have several treating physicians. The commenter recommended that the referring physician provide the patient with a list of all physician owners who are actively practicing at the hospital. Another commenter believed that a referring physician hospital owner, especially in an emergency room setting, will not have an early opportunity to inform the patient of the treating physician's ownership interests in the hospital. The commenter was concerned that the disclosure process could place the patient in danger by delaying patient care in order to provide timely ownership disclosure information.

Response: We suggested in the preamble to the proposed rule that a referring physician could use a written, form notice to disclose his or her ownership interest to the patient. Also, we suggested that the referring physician could disclose the ownership interest of one or more treating physicians by directing the patient to review a list of other investors in the hospital. As we stated above, no disclosure by a physician owner is necessary with respect to a patient whom the physician treated in a hospital emergency department.

Comment: Several commenters stated that the statutory provision at section 1877(i)(1)(C)(iv) of the Act requiring hospitals to disclose physician ownership information on the hospitals' Web sites could be accomplished by placing such information on the home page or "about us" section on the Web sites. The commenters also believed that the disclosures on the Web sites should be clearly visible to the typical reader.

Response: We agree with the recommendations made by the commenters. We believe a hospital could satisfy this requirement by including on one location within its public Web site a list of the physician owners who actively practice at the facility. A list of the physician owners should be located in a conspicuous place on the Web site, on a page that is commonly visited by current or potential patients, such as the home page or "about us" section. We also believe the physician ownership information should be readily legible and in a size that is consistent with other text on the Web site.

Comment: One commenter recommended that the hospital requirement to disclose hospital ownership information in any public advertising should be limited to specific activities and should not be required in all public advertising. The commenter suggested that the inclusion of physician ownership information in its public advertising should apply only to direct mail, Internet, and other print communications where such communication can be read and fully understood. The commenter believed that a hospital should not be required to include disclosures in other advertising, such as the kind found on billboards, or radio and television. Another commenter also recommended that hospital disclosures in public advertising should be confined to print media such as newspapers, magazines, and other internally produced print material for public use.

Response: We have no flexibility regarding the disclosure of hospital ownership information. Section 1877(i)(1)(C)(iv) of the Act requires that the hospital disclose the fact that the hospital is partially owned or invested in by physicians in "*any* public advertising" for the hospital. We believe that the disclosure can be satisfied by simply adding a sentence to this effect in public advertisements. We agree that a hospital also is required to disclose this information in a clear and readable manner in any of its print advertising made available to the public, such as direct mailings and other print communications, for example, newspapers and magazines.

In addition, we are finalizing our proposed § 411.362(b)(3) regarding "Preventing Conflicts of Interest" with one technical change. We are making a

technical correction to proposed § 411.362(b)(3)(ii)(C) by replacing "or" with "and" in order to conform to the precise language of section 1877(i)(1)(C)(iv) of the Act.

4. Ensuring Bona Fide Investment

Section 1877(i)(1)(D) of the Act sets forth seven different requirements related to ensuring *bona fide* investment in order for hospitals to qualify for the rural provider and whole hospital exceptions set forth in the physician self-referral law. First, the percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors, in the aggregate may not exceed such percentage as of March 23, 2010. Second, any ownership or investment interests that the hospital offers to a physician owner or investor must not be offered on more favorable terms than the terms offered to a person who is not a physician owner or investor. Third, the hospital (or any owner or investor in the hospital) must not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor. Fourth, the hospital (or any owner or investor in the hospital) must not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital. Fifth, ownership or investment returns must be distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital. Sixth, physician owners and investors must not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital. Lastly, the hospital must not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor. We note that additional or different factors may be relevant to a determination of whether an investment is *bona fide* for purposes of complying with other laws, including fraud and abuse laws.

In the August 3, 2010 proposed rule (75 FR 46434), we proposed to add § 411.362(b)(4) to incorporate these provisions in our regulations. We stated that we recognized that section 1877(i)(1)(A) of the Act provides that the hospital must have had physician ownership or investment on December 31, 2010, while section 1877(i)(1)(D)(i) of the Act assumes the existence of physician ownership or investment on March 23, 2010 and further provides that the percentage of the total value of physician ownership or investment interests held in the hospital, in the aggregate, on that date must not increase. Reading these provisions together, we conclude the following: (i) If a hospital had no physician ownership or investment as of March 23, 2010, it will not qualify for the whole hospital or rural provider exceptions if it adds any physician owners or investors after that date; and (ii) if a hospital had physician ownership or investment as of March 23, 2010, it may reduce the number of physician owners or investors, provided that the percentage of the total value of physician ownership or investment interests, in the aggregate, remains the same or decreases.

The second through seventh requirements tied to ensuring *bona fide* investment (sections 1877(i)(1)(D)(ii) through 1877(i)(1)(D)(vii) of the Act) do not specify any deadlines for compliance. Accordingly, compliance with the second through seventh requirements must be achieved no later than September 23, 2011.

In the proposed rule, we stated that if we determine that further guidance related to any aspect of section 1877(i)(1)(D) of the Act is necessary, we would provide clarification in future rulemaking. Furthermore, a hospital may request an advisory opinion (pursuant to §§ 411.370 through 411.389) for a determination of whether an existing or proposed arrangement meets the requirements for hospitals to ensure that investment is *bona fide*.

Comment: Some commenters stated that CMS should clarify whether section 1877(i)(1)(D) of the Act would be violated if the total value of ownership or investment interests held in the hospital by physicians in the aggregate (the "bona fide investment level") fluctuates. For example, one commenter inquired whether a hospital could repurchase the ownership interest held by a recently deceased physician (thereby reducing the bona fide investment level) and later resell that ownership interest to another physician, returning the bona fide investment limit to the same level it was on March 23, 2010.

Response: The bona fide investment level may fluctuate as long it never exceeds the level that existed on March 23, 2010.

Comment: Many commenters stated that CMS should clarify whether a hospital can reduce or increase the number of physician owners as long as the percentage of the total value of physician ownership remains unchanged. The commenters believed that nothing in the statute precludes the addition of new physician owners as long as the percentage of ownership remains constant.

Response: We agree that section 1877(i)(1)(D) of the Act does not restrict the number of physicians that may have an ownership interest in a hospital. The bona fide investment level requirement would not be violated as long as the percentage of the total value of the ownership or investment interest held in the hospital by physician owners in the aggregate does not exceed such percentage as of March 23, 2010.

Comment: One commenter sought confirmation that a hospital wishing to recruit a new physician would be able to give some ownership units from one physician to another new physician.

Response: Any arrangement in which a hospital or physician owner "gives" to another physician an ownership or investment interest in the hospital is highly suspect. We assume the commenter is inquiring whether section 1877(i)(1)(D)(i) of the Act would be violated if one or more physician owners transferred some of their shares in the hospital to the recruited physician for fair market value, possibly at the request of the hospital. This provision would not be violated as long as the bona fide investment level does not exceed that which existed as of March 23, 2010. In addition, the parties should carefully review the arrangement to ensure that it fully complies with the physician recruitment exception at § 411.357(e), the anti-kickback statute, and any other applicable laws.

Comment: Several commenters addressed the situation in which a hospital has physician owners, but no Medicare provider agreement, as of March 23, 2010. One commenter sought clarification that the level of physician ownership can increase prior to December 31, 2010. Several other commenters disagreed with this interpretation and requested that CMS explicitly state that the bona fide investment level is capped as of March 23, 2010 even if the hospital does not have a Medicare provider agreement as of that date.

Response: The bona fide investment level may not increase for any hospital with physician owners as of March 23, 2010, regardless of whether the hospital has a Medicare provider agreement as of that date. In addition, as we indicated in the proposed rule (75 FR 46432), if a hospital has no physician owners or investors on March 23, 2010, the hospital will not satisfy the whole hospital or rural provider exception if it later adds physician owners or investors.

Comment: One commenter inquired as to whether the *bona fide* investment level is based on the aggregate percentage of the *number* of shares held by physicians or the aggregate percentage of the *value* of shares held by physicians. The commenter suggested that the more workable option is for the limit to be based on a strict percentage of the number of outstanding shares. The commenter further contended that basing the limit on a hospital's value would require the hospital to ascertain its value on a regular basis to make certain that the aggregate value of the physicians' ownership never exceeds the March 23, 2010 limit.

Response: We are not adopting the commenter's suggestion. Section 1877(i)(1)(D) of the Act refers to "the total value of the ownership or investment interests held in the hospital * * * by physician owners or investors in the aggregate" as of March 23, 2010. The plain language of the statute refers to the value of the investment interests, not the number of shares held by physicians.

Comment: A few commenters presented differing scenarios that involved the sale of ownership shares in a hospital. The commenters stated that the statute does not appear to impose any restrictions on the ability to transfer ownership pursuant to a sale of the ownership/investment interests but, nevertheless, believed it would be important for CMS to clarify this issue. One commenter asserted that the statutory language does not prohibit private sales among physician owners/investors where the bona fide investment level in the hospital remains unchanged.

Response: We agree with the commenters. The statute does not restrict the transfer of physician ownership interests pursuant to a bona fide sale, as long as the percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate would not exceed the percentage as of March 23, 2010.

Comment: One commenter representing a hospital system requested clarification concerning whether hospitals may continue to condition a physician's ownership interest on his or her continued practice of medicine and require the physician to divest his or her investment interest in the hospital if the physician retires or ceases to practice medicine in the community served by the hospital.

Response: Section 1877(i)(1)(C)(iii) of the Act prohibits a hospital from conditioning any physician ownership or investment interest either directly or indirectly on the physician's ability to make or influence referrals to the hospital. Depending on the facts, the conditions described by the commenter could implicate this provision.

Comment: Some commenters believed that the bona fide investment level should be calculated without regard to any ownership or investment interests held by physicians who do not make any referrals to the hospital, including physicians who are no longer practicing medicine. The commenters asserted that the purchase of a referring physician's ownership interest by a non-practicing, non-referring physician should not be prohibited by the statute because it has no potential for program or patient abuse. They suggested various revisions to the regulation to avoid this result, including amendments to the definition of "referral," "referring physician," and the creation of a new exception using our authority under section 1877(b)(4) of the Act.

Response: The ownership or investment interests of nonreferring physicians need not be considered when calculating the baseline physician ownership level. Section 1877(i)(1)(D)(i) of the Act provides that the percentage of the total value of the ownership or investment interests held in the hospital by "physician owners or investors" in the aggregate may not exceed such percentage that existed on March 23, 2010. Section 1877(i)(5) broadly defines "physician owner or investor" to include any physician with a direct or indirect ownership or investment interest in the hospital. Under the definition of "indirect ownership or investment interest" at § 411.353(b)(5), only "referring physicians" can have an indirect ownership or investment interest in a DHS entity. We caution that we would view with great suspicion any arrangements in which physician owners or investors of a hospital in one State engage in a mutually beneficial cross-referral or cross-investment scheme with physician owners or investors of a hospital in another State.

Comment: Two commenters asserted that CMS minimized the significant difficulty hospitals will experience in monitoring and measuring the bona fide investment level, particularly with respect to indirect ownership interests held by non-referring physicians. The commenters stressed that it is unlikely that entities investing in hospitals such as trusts, private equity funds, and contractually affiliated health care providers, monitor whether they or their shareholders are directly or indirectly owned by physicians, particularly if those physicians are not referring physicians or physicians on the medical staff of the hospital. The commenters further stated that interests in hospitals may be transferred voluntarily in subsequent transactions beyond the reach of the hospital, or involuntarily through devise or bequest. The commenters contended that monitoring these transactions is a daunting task not suited to the normal operations of a hospital.

Response: We appreciate the commenters' concerns. Section 6001 defines the term "physician owner or investor" to mean "a physician (or immediate family member of such physician) with a direct or indirect ownership or investment interest in the hospital." Under the definition of "indirect ownership or investment interest" at § 411.353(b)(5), there must be an unbroken chain of ownership or investments between the referring physician and the DHS entity and the DHS entity must have actual knowledge of, or act in reckless disregard or deliberate ignorance of, the fact that the referring physician (or immediate family member) has some ownership or investment interest in the entity furnishing DHS. Thus, the bona fide investment level may be calculated without regard to any ownership or investment interest that does not satisfy this standard. We note that, as provided in § 411.354(b)(5)(ii), an indirect ownership or investment interest exists even though the DHS entity does not know, or acts in reckless disregard or deliberate ignorance of, the precise composition of the unbroken chain or the specific terms of the ownership or investment interests that form the links in the chain.

Comment: One commenter sought clarification regarding the requirement at section 1877(i)(1)(D)(iii) of the Act, which provides that a hospital may not directly or indirectly provide loans or financing to assist a physician acquiring an investment in the hospital. The commenter requested clarification that this limitation will not affect the current practice whereby an affiliate (for

example, a parent company) makes a loan to a hospital that has physician owners when the terms of such loans are commercially reasonable, provide for an interest rate above the lender's cost of funds, are secured by the assets of the borrower, and are repaid at maturity prior to distribution to the investors.

Response: Section 1877(i)(1)(D)(iii) of the Act would not preclude the parent company from making a loan to the physician-owned hospital, as long as the loan is being made and used for purposes other than assisting physicians in the acquisition of ownership or investment interests in the hospital.

After consideration of the public comments we received, we are finalizing proposed § 411.362(b)(4), with the modification to paragraph (b)(4)(i) discussed above.

5. Patient Safety

Section 1877(i)(1)(E) of the Act, as added by the Affordable Care Act, requires a hospital that is owned or invested in by physicians to disclose to a patient before admission if it does not have a physician available on the premises to provide services during all hours that the hospital is providing services to such patient. Following this disclosure, the hospital must receive a signed acknowledgment of such fact from the patient. In addition, the hospital must have the capacity to provide assessment and initial treatment for patients and refer and transfer such patients to hospitals with the capability to treat the patients involved. We see no reason to treat the safety of inpatients differently than outpatients. Accordingly, given the language and purpose of the statute, in the August 3, 2010 proposed rule (75 FR 46434), we proposed to apply these patient safety requirements to inpatients as well as outpatients. Hospitals must meet these requirements no later than September 23, 2011. We proposed to incorporate these provisions into our regulations at § 411.362(b)(5).

Comment: One commenter questioned whether a hospital would be in compliance with the exception contained in § 411.362(b)(5)(i) if it inadvertently failed to obtain a written acknowledgment from the patient stating that the patient understood that a physician was not available to provide services during all hours that the hospital was providing services to such patient.

Response: A failure by the hospital to obtain a signed acknowledgment from the patient, inadvertent or not, would constitute non-compliance with this statutory provision. As a matter of prudent business practice, hospitals should include the notice with other papers that must be signed by the patient or the patient's representative at the time of registration.

Comment: One commenter recommended that the hospital's responsibility to obtain the patient's signed acknowledgment, following the hospital's preadmission disclosure to the patient that the hospital does not have a physician available on the premises to provide services during all hours in which the hospital is providing services to the patient, should be done in conjunction with the registration process and not in advance of admission.

Response: If a hospital obtains the required signed acknowledgment during a registration process that occurs prior to admission, the hospital would be in compliance with this statutory provision.

Comment: One commenter suggested that a physician-owned hospital would meet the requirement of having physician coverage 24 hours a day, 7 days a week if the hospital physically adjoins another hospital and there is a coverage and transfer agreement in place that requires immediate presence of a physician to address the issue. The commenter believed such a physician-owned hospital should not be required to make a preadmission disclosure to a patient in accordance with section 1877(i)(1)(E)(i) of the Act.

Response: In the situation described, because the physician-owned hospital will always have a physician available on its premises to provide services during all hours in which the hospital is providing services to a patient, we agree that the hospital would not be required to make the preadmission disclosures mandated by section 1877(i)(1)(E)(i) of the Act.

Comment: One commenter supported the proposed amendment to § 482.12, which would require hospitals, as a condition of participation, to have the capacity to provide assessment and initial treatment for all patients and the ability to transfer patients to hospitals that have the ability to treat the patients. The commenter sought clarification regarding the terms "capacity" and "initial treatment" and inquired if the provision was intended to apply to inpatients, outpatients, or emergency department patients.

Response: We withdraw this proposal. We do not believe it is necessary to modify the hospital conditions of participation to reflect the provision in section 1877(i)(1)(E)(ii) of the Act.

In this final rule, we are finalizing proposed § 411.362(b)(5) regarding "Patient Safety" without modification.

6. Conversion From ASC

Section 1877(i)(1)(F) of the Act, as added by the Affordable Care Act, also prohibits the use of the rural provider and whole hospital exceptions by physician-owned hospitals that were converted from an ASC to a hospital on or after March 23, 2010. We proposed to add § 411.362(b)(6) to reflect this provision in our regulations.

Comment: Two commenters stated that the proposed rule did not offer any guidance as to what constitutes a "conversion." The commenters urged CMS to provide further guidance.

Response: We decline to provide a specific definition of "conversion." Whether an ASC has been converted to a physician-owned hospital on or after March 23, 2010 will depend on the facts. In some cases, the existence of a conversion may be obvious (for example, when an ASC that is wholly-owned by physicians terminates its Medicare ASC agreement on June 1, 2010, and obtains a Medicare hospital provider agreement or hospital license effective on or after June 1, 2010, for a hospital that occupies the same premises as the former ASC and is physician owned). Parties may submit an advisory opinion request pursuant to § 411.372 if they are uncertain whether a conversion has occurred.

After consideration of the public comments we received, we are finalizing, without modification, our proposed regulations at § 411.362(b)(6) that the hospital must not have been converted from an ASC to a hospital on or after March 23, 2010.

7. Publication of Information Reported

Section 1877(i)(2) of the Act requires that the Secretary publish, and update on an annual basis, the information submitted by hospitals under section 1877(i)(1)(C) of the Act on the CMS Web site. As with the annual report requirement set forth in section XVIII.B. of the proposed rule (now section XXII.B. of this final rule), we did not make a proposal related to this provision in the proposed rule. We did not receive any public comments regarding this matter.

8. Enforcement

Section 6001(b)(1) of the Affordable Care Act requires the Secretary to establish policies and procedures to ensure compliance with the requirements described in section 1877(i) of the Act, and states that these policies and procedures may include

unannounced site reviews of hospitals. Section 6001(b)(2) of the Affordable Care Act requires the Secretary, beginning no later than May 1, 2012, to conduct audits to determine if physician-owned hospitals are in compliance with section 1877(i)(1) of the Act. In the August 3, 2010 proposed rule (75 FR 46434 through 46435), we indicated that we would comply with the statutory mandate, but did not propose any regulations on this topic at that time.

Comment: Several commenters noted that the proposed rule did not address enforcement procedures. The commenters asserted that more guidance is necessary for hospitals to align their actions with section 6001 of the Affordable Care Act. One of the commenters urged CMS to conduct open door forum calls and other outreach efforts to educate hospitals and physicians concerning enforcement procedures.

Response: As stated in the proposed rule (75 FR 46434 through 46435), we will comply with the statutory mandate and provide hospitals and physicians with further guidance after the rules are finalized. In addition, we will explore various forms of outreach, including, but not limited to, open door forums.

D. Related Changes to Provider Agreement Regulations

Section 1866 of the Act states that a provider of services shall be qualified to participate in the Medicare program and shall be eligible for Medicare payments if it files a Medicare provider agreement and abides by the requirements applicable to Medicare provider agreements. These requirements are incorporated in our regulations at 42 CFR Part 489, Subparts A and B (Provider Agreements and Supplier Approval). Section 1861(e) of the Act defines the term "hospital." Section 1861(e)(9) of the Act defines a hospital and authorizes the Secretary to establish requirements as determined necessary in the interest of patient health and safety. Section 5006 of the Deficit Reduction Act of 2005 mandated the Secretary to develop a strategic and implementing plan to address certain issues with respect to physician ownership of specialty hospitals. As part of that plan, we used our authority under sections 1866 and 1861(e)(9) of the Act (as well as our general rulemaking authority under sections 1102 and 1871 of the Act) to impose certain additional requirements on physician-owned hospitals as part of their provider agreements. These new requirements were established in the FY 2008 IPPS final rule with comment period (72 FR 47385 through 47391) and the FY 2009 IPPS final rule (73 FR 48686 through 48688).

Specifically, we amended the regulations at § 489.3 governing Medicare provider agreements to define a "physician-owned hospital" as any participating hospital (including a CAH) in which a physician or immediate family member of a physician has an ownership or investment interest, unless the ownership or investment interest satisfies the exceptions at § 411.356(a) or (b) regarding publicly-traded securities and mutual funds. In addition, we added a new provision at § 489.20(u)(1) to require a physician-owned hospital to agree to furnish patients with written notice, in a manner reasonably designed to be understood by all patients, that it is physician-owned and that the list of physician owners is available upon request. Further, we added a new provision at § 489.20(u)(2) to compel hospitals to require that all physician owners who are also members of the hospital's medical staff to disclose, in writing, their ownership interest in the hospital (and that of any immediate family member) to all patients they refer to the hospital, as a condition of continued medical staff membership. Patient disclosure is required at the time the physician makes a referral.

We also added a new provision to require that hospitals and CAHs: (1) Furnish all patients written notice at the beginning of their inpatient hospital stay or outpatient service if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week; and (2) describe how the hospital or CAH will meet the medical needs of any patient who develops an emergency medical condition at a time when no physician is present in the hospital or CAH. These requirements are codified at § 489.20(w). The requirements of §§ 489.20(u) and (w) were made applicable to both inpatient hospital stays and outpatient services because, as we stated in the FY 2008 IPPS final rule with comment period, these provisions are in the interest of the health and safety of all individuals who receive services in these institutions. The notice requirements are intended to permit individuals to make more informed decisions regarding their treatment.

In the August 3, 2010 proposed rule (75 FR 46435), we proposed to modify the Medicare provider agreement regulations in Subpart B of Part 489 in order to make the rules consistent with new § 411.362, as required by the Affordable Care Act. We stated our belief that incorporating the additional requirements of the Affordable Care Act into Part 489 would be in the best interest of the health and safety of individuals who receive services in hospitals and CAHs. With respect to § 489.20(u), we proposed to: (1) Add a provision in § 489.20(u)(1)(ii) to specify that the hospital must disclose on any public Web site for the hospital and in any public advertising that it is owned or invested in by physicians; (2) amend § 489.20(u)(2) to specify that a referring physician owner or investor must also disclose in writing, if applicable, the treating physician's ownership or investment interest in the hospital; and (3) add § 489.20(u)(3) to specify that a hospital may not condition any physician ownership or investment interests either directly or indirectly on the physician making or influencing referrals to the hospital or otherwise generating business for the hospital.

Regarding § 489.20(w), we proposed to specify that, in the case of a hospital where a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week, before admitting a patient or providing an outpatient service, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during all hours services are rendered to the patient.

We encouraged public comments on whether the changes to the provider agreement regulations (Part 489) are necessary or whether the amendments and additions made to the whole hospital and rural provider exceptions within subpart J of Part 411 of our regulations are sufficient to provide guidance relating to section 6001 of the Affordable Care Act.

Comment: Two commenters suggested that any changes to the existing provider agreement regulations in 42 CFR part 489 are unnecessary. The commenters stated that the proposed amendments to the whole hospital and rural provider exceptions in 42 CFR part 411, subpart J are sufficient to provide guidance to physician-owned hospitals. Another commenter supported entirely the proposal to make conforming changes to the provider agreement regulations.

Response: We are persuaded by the commenters who suggested that the proposed amendments and additions made to the whole hospital and rural provider exceptions in subpart J of part 411 are sufficient for providing the necessary guidance to physician-owned hospitals. For the most part, the proposed conforming language we added to the provider agreement regulations does not substantively

impact the health and/or safety of patients. As a result, we are not finalizing the following proposed modifications to part 489: (1) In § 489.20(u)(1)(ii) concerning a hospital's responsibility to disclose physician ownership on a Web site and in any public advertising; (2) in § 489.20(u)(2) concerning a referring physician's responsibility to disclose to the patient any ownership interest in the hospital by a treating physician; and (3) in § 489.20(u)(3) concerning a hospital's responsibility not to condition any physician ownership either directly or indirectly on the physician owner making or influencing referrals to the hospital or otherwise generating business for the hospital.

However, we are finalizing, as proposed, § 489.20(w)(2), which requires a hospital to obtain a signed acknowledgment from a patient (before admitting the patient or providing an outpatient service to the patient) stating that the patient understands that a physician may not be present during all hours services are furnished to the patient. This provision is important to include in Part 489 as it addresses the patient health and safety concerns raised by the Affordable Care Act.

E. Conditions of Participation for Hospitals

In the proposed rule, we inadvertently included proposed changes to the regulatory text at § 482.12(g), concerning the condition of participation for a hospital's governing body. As discussed above, in this final rule, we are withdrawing this proposal.

F. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and to solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In the August 3, 2010 proposed rule (75 FR 46436), we solicited public comments on each of the issues outlined above regarding the provisions of section 6001 of the Affordable Care Act relating to physician self-referrals that were discussed in section XVIII.A. through D. of the proposed rule (now in sections XXII.A through D. of this final rule) that contained information collection requirements. We discuss these provisions below and address any public comments that we received in response to our solicitation.

As discussed in section XVII.C.4. and D. of the preamble of the August 3, 2010 proposed rule (and section XXII.C.4. and D. of this final rule), current § 489.20(u)(1) states that, in the case of a physician-owned hospital as defined in § 489.3, the hospital must furnish written notice to all patients at the beginning of their hospital stay or outpatient visit that the hospital is a physician-owned facility. Current § 489.20(u)(2) provides that hospitals must require each physician who is a member of the hospital's medical staff to agree, as a condition of his or her continued medical staff membership or admitting privileges, to disclose in writing to all patients the physician refers to the hospital any ownership or investment interest held by the physician or an immediate family member of the physician. We proposed to amend § 489.20(u)(2) to correspond to changes we proposed at the same time to the physician self-referral regulations. Specifically, we proposed to modify § 489.20(u)(2) to expand the physician disclosure obligation to include disclosure of the treating physician's ownership or investment interest in the hospital. The burden associated with the requirements in this section is the time and effort necessary for hospitals and physicians to furnish the required notices. This requirement is subject to the PRA; however, the associated burden under the existing § 489.20(u) is currently approved under OCN 0938–1034, with a February 28, 2011 expiration date.

Section 6001 of the Affordable Care Act amended the rural provider and whole hospital exceptions to the physician self-referral prohibition in section 1877 of the Act. To implement these provisions, we proposed to add § 411.362 to our regulations and to amend § 489.20(u)(2) (we note that we are not finalizing the proposed amendment to § 489.20(u)(2) in this final rule, as discussed below). We proposed new § 411.362(b)(3)(ii)(A), which would require physician-owned hospitals to have procedures in place to require that each referring physician agree, as a condition of his or her continued medical staff membership or admitting privileges, to provide written disclosure of his or her ownership or investment interest in the hospital (and, if applicable a treating physician's ownership or investment interest in the hospital) to all patients whom the physician refers to the hospital. This provision imposes a burden on both hospitals and physicians.

With respect to hospitals, we indicated in the proposed rule that the burden associated with this requirement is the time and effort necessary for hospitals to develop, draft, and implement changes to its medical staff bylaws and other policies governing admitting privileges. Approximately 265 hospitals would be required to comply with these requirements. We estimate that it would require a hospital's general counsel 2 hours to revise a hospital's medical staff bylaws and policies governing admitting privileges. Therefore, the total annual hospital burden would be 530 hours at a cost of $32,875.90. As discussed earlier in section XXII.D. of this final rule, based upon public comments we received, we are not finalizing the proposed amendment to § 489.20(u)(2) that the referring physician must provide written disclosure of the treating physician's ownership or investment interest in the hospital. However, we are finalizing the proposed requirement at § 411.362(b)(3)(ii)(A).

With respect to physicians, the burden associated with this requirement is the time and effort necessary for a referring physician owner or investor to develop a list of all other physician owners or investors in the hospital and draft a formal notice to patients that discloses the referring physician's ownership or investment interest in the hospital, informs the patient that his or her treating physician(s) may have an ownership or investment interest in the hospital, and directs the patient to review a list identifying all other physician owners or investors in the hospital. This list may be used by patients in making their health care decisions. Under existing § 489.20(u)(1), hospitals are currently required to provide a list of their physician owners or investors to patients upon request at the beginning of their inpatient stay or outpatient visit. Because hospitals already maintain lists of their owners and investors, we estimate that it will take each physician 1 hour annually to obtain such a list from the hospital, draft a disclosure notice, and make copies that will be distributed to patients. In addition, we estimate that it will take 30 seconds to provide the

disclosure notice to each patient and an additional 30 seconds to record proof of disclosure in each patient's medical record. Although we can estimate the number of physician-owned hospitals, we are unable to quantify the number of physicians (or their immediate family members), who possess an ownership or investment interest in hospitals. There are limited data available concerning physician ownership in hospitals. The studies to date, including those by CMS and the GAO, pertain to physician ownership in specialty hospitals (cardiac, orthopedic, and surgical hospitals). These specialty hospitals published data concerning the average percentage of shares of direct ownership by physicians (less than 2 percent), indirect ownership through group practices, and the aggregate percentage of physician ownership, but did not publish the number of physician owners in these types of hospitals. More importantly, § 489.20(u)(2) applies to physician owners of any type of hospital. Our other research involved a review of enrollment data. However, the CMS Medicare enrollment application (CMS–855) requires physicians to report only those ownership interests that are 5 percent or more (direct or indirect), and thus, most physician ownership is not captured. While we acknowledge there is a burden associated with this information collection requirement, we have no way to quantify this requirement's burden. Therefore, because we are unable to estimate the total physician burden associated with this reporting requirement, we proposed to assign 1 burden hour to this requirement. We sought public comments pertaining to this burden. However, we did not receive any public comments. Therefore, we are finalizing the burden estimate of 1 hour.

Existing § 489.20(w) requires hospitals, as defined in § 489.24(b), to furnish all patients notice in accordance with § 482.13(b)(2), at the beginning of their hospital stay or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week. The notice must indicate how the hospital will meet the medical needs of any inpatient who develops an emergency medical condition, as defined in § 489.24(b), at a time when there is no physician present in the hospital. The burden associated with this requirement is the time and effort necessary for each hospital to develop a standard notice to furnish to its patients. Although this requirement is subject to the PRA, the associated burden is approved under OCN 0938–1034, with an expiration date of February 28, 2011.

Sections 489.20(w)(2) and 411.362(b)(5)(i) require that, following a hospital's disclosure to a patient that it does not have a physician available during all hours that the hospital is providing services to such patient, the hospital must obtain a signed acknowledgment from the patient stating that the patient understands that no physician is available for that period. The burden associated with these requirements is the time and effort necessary for each hospital to add an acknowledgment line to its current form, disclose the form to the patient, obtain the patient's signature, and copy and record the form in the patient's medical record. The requirements in § 489.20(w) applies to all hospitals (not just physician-owned hospitals), as defined in § 489.24(b). We estimate that there are approximately 2,557 hospitals and CAHs that may not have a physician on site at all times. We estimate that it will take each hospital 30 minutes to amend its current disclosure form to add an acknowledgment line, an additional 30 seconds to obtain the patient's signature, and an additional 30 seconds to include a copy of the notice in the patient's medical record. The estimated annual burden associated with developing an amended form, obtaining patient signatures, and copying and recording the form is 1,196,932.6 hours at a cost of approximately $18,518,081. We did not receive any public comments regarding this requirement. Therefore, we are finalizing the burden estimate as proposed.

Section 411.362(b)(3)(ii)(C) requires disclosure by a hospital, on any public Web site for the hospital and in any public advertising, that the hospital is owned or invested in by physicians. The burden associated with this disclosure requirement is the time and effort necessary for hospitals to draft and post such a disclosure on their Web sites (where applicable) and to include such a disclosure in any existing or future public advertising that the hospitals may utilize. We estimate that 265 hospitals will be required to comply with this requirement. In addition, we estimate that it will take each hospital 1 hour to develop and place this information on its Web site and/or in a public advertisement. The estimated annual hospital burden associated with placing the aforementioned information in Web sites, public advertisement, or both is 265 hours at a cost of $3,993.55. In addition, we estimate that it will take 30 minutes annually for a hospital to review and update the information contained in its Web site, public advertising or both. The estimated annual burden associated with the annual review and update of the information is 132.5 hours at a cost of $1,996.77. As discussed in section XXII.D. of this final rule), we have concluded that a proposed conforming change to § 489.20(u)(1)(ii) is unnecessary, and therefore, we are not finalizing that proposed regulation.

G. Regulatory Flexibility Analysis

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), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules that have economically significant effects ($100 million or more in any 1 year) or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal government or communities (58 FR 51741).

We have determined that this final rule is not a major rule as defined in 5 U.S.C. 804(2).

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Many hospitals are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (hospitals having revenues of $34.5 million or less in any 1 year). (For details on the latest standards for health care providers, we refer readers to the SBA's Web site at: *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series).) For purposes of the RFA, we have determined that many

hospitals will be considered small entities according to the SBA size standards. Individuals and States are not included in the definition of a small entity.

As discussed in sections XXII.A. through D. of this final rule, section 6001 of the Affordable Care Act amended section 1877 of the Act to impose additional requirements in order to qualify for the rural provider and hospital ownership or investment exceptions. Our policies in this final rule incorporate these requirements into our regulations. Most physicians who have ownership or investment interests in hospitals ("physician-owned hospitals") and who refer DHS to the hospital, are subject to the physician self-referral prohibition, and are unable to qualify for the ownership and investment exception at section 1877(d)(1) of the Act. Section 1877(d)(1) of the Act provides an exception for ownership or investment in publicly traded securities in a corporation where there is stockholder equity exceeding $75 million at the end of the corporation's most recent fiscal year or on average during the previous 3 fiscal years; or the ownership or investment interest involves mutual funds in a company that has assets greater than $75 million. Studies by the OIG and GAO have concluded that physician-owned hospitals tend to be smaller and are unable to meet the $75 million threshold. Therefore, most physician-owned hospitals avail themselves of the rural provider or hospital ownership exceptions (sections 1877(d)(2) and (d)(3) of the Act, respectively).

Our revisions to the regulations limit the creation of new Medicare-participating hospitals in which physician owners or investors intend to refer patients for DHS by requiring such hospitals to have physician ownership and a provider agreement in effect on December 31, 2010, as provided for by section 6001 of the Affordable Care Act. This revision affects facilities with physician ownership or investment that are currently under development but may be unable to have a provider agreement in effect on December 31, 2010. We believe there are only a few facilities or hospital projects under development that will be unable to meet either of these criteria.

In addition to the effect on the creation of new physician-owned hospitals, the revision of the regulations to incorporate the provisions of section 6001 of the Affordable Care Act will impact existing physician-owned hospitals that currently avail themselves of the rural provider or whole hospital exception. Specifically, a physician-owned hospital is prohibited from expanding the number of beds, operating rooms, and procedure rooms beyond those for which it was licensed as of March 23, 2010, or, in the case of a hospital that did not have a provider agreement in effect as of this date but does have a provider agreement in effect on December 31, 2010, the effective date of the provider agreement. We believe there are some hospitals that were in the midst of an expansion that was not completed by March 23, 2010 (or, in the case of a hospital that did not have a provider agreement in effect as of this date but does have a provider agreement in effect on December 31, 2010), and thus, may not be able to use the new beds, operating rooms, and procedures rooms. We believe that most facilities and their investors were aware of the possible legislation that will limit facility expansion and, thus, did not continue to pursue expansion of their facilities.

Our regulations require hospitals to have procedures in place that require referring physicians to disclose to patients the referring physicians' ownership or investment interests in the hospital, as well as any ownership or investment interest in the hospital held by a treating physician. This policy also requires hospitals to disclose on any public Web site for the hospital or in any public advertising that it is owned or invested in by physicians. Finally, under the revision of the regulations, a hospital may not condition any physician ownership or investment either directly or indirectly on the physician making or influencing referrals to the hospital or otherwise generating business for the hospital. Most physician-owned hospitals comply with the current provisions of § 489.20(u). Thus, they have procedures in place to require referring physician owners or investors to disclose their ownership or investment interests to patients. We believe most physicians and hospitals will be minimally affected by the additional requirements.

Our revisions to the regulations require that hospitals must ensure that all ownership and investment interests are *bona fide*, a step that we believe most prudent hospitals are already undertaking. We believe most of the new statutory and regulatory provisions will have little, if any, impact on physician-owned hospitals or physicians. The only provision that may have a minor impact is the provision found under section 1877(i)(1)(D)(*i*) of the Act and § 411.362(b)(4)(i) of the regulations that prohibits physician-owned hospitals from increasing the percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors beyond that which existed on March 23, 2010. Therefore, hospitals and other entities that own the hospital must monitor the percentages of ownership or investment to ensure that the percentage is not increased. We believe this provision will have a minor effect on some hospitals and their physician owners or investors.

Our revisions to the regulations also require hospitals to take certain steps to ensure patient safety, most of which are practices or procedures that we believe most hospitals currently undertake. Building upon the safety requirements found in existing § 489.20(w), we are requiring under §§ 411.362(b)(5)(i) and 489.20(w)(2) that, before admitting a patient, a hospital that does not have a physician available on the premises to provide services during all hours in which the hospital is providing services to the patient, must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during the time services are furnished to a patient. In addition, §§ 411.362(b)(5)(ii) and 489.20(w)(1) will require hospitals to have the capacity to provide assessment and initial treatment for patients and the ability to refer and transfer patients to hospitals with the capability to treat the needs of the patient involved. We believe requesting a signed acknowledgment will impose a minimal burden on hospitals. Also, most hospitals currently have in place procedures to ensure that they have the capacity to provide assessment and initial treatment for patients and the ability to refer and transfer patients.

Lastly, our revisions to the regulations prohibit a facility that was previously an ASC and was converted into a hospital from qualifying for the rural provider or whole hospital ownership exceptions to the self-referral prohibition. Although we have no direct data on this issue, we believe there are only a few ASCs that are being converted to a hospital, and, thus, the effect is minimal.

The changes concerning disclosure of physician ownership in hospitals and patient safety are consistent with the physician self-referral statute and regulations, our existing regulations governing basic commitments of providers, and the current practices of most hospitals. Thus, our requirements will present a negligible impact on physician-owned hospitals. Physician-owned hospitals will have a one-time cost associated with creating or modifying a notice to be used when a physician is not on the premises 24

hours a day. In addition, these hospitals will incur the costs associated with ensuring that a signed acknowledgment is received from patients. Similarly, the costs borne by individual physicians to implement the provisions will be limited to a one-time cost associated with developing a disclosure notice that discloses the ownership of the referring and, where applicable, the treating physician.

Overall, we believe that beneficiaries will be positively impacted by these provisions. Specifically, additional information concerning disclosures of ownership and patient safety measures equip patients to make informed decisions about where they elect to receive care. Our policies make no significant changes that have the potential to impede patient access to health care facilities and services. We believe that our policies are necessary to conform our regulations to the amendments to section 1877 of the Act. We also believe the regulations will help minimize anticompetitive behavior that can affect the decision as to where a beneficiary receives health care services and will possibly enhance the quality of the services furnished.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban areas. Thus, we continue to classify these hospitals as urban hospitals.

We believe that our policies in this final rule will affect a relatively small number of physician-owned hospitals and physicians. We are uncertain of the exact numbers of hospitals with physician ownership or investment that will be impacted by the policies and their restrictions. However, the most recent studies by CMS (August 8, 2006 Final Report to the Congress Required under Section 5006 of the Deficit Reduction Act of 2005) and MedPAC (June 2005 Report to the Congress) concluded that there were approximately 128 physician-owned specialty hospitals (those that focus primarily on patients with a cardiac condition, orthopedic condition, or those receiving a surgical procedure). We recognize that there are other hospitals with physician ownership that do not meet the definition of a specialty hospital but we do not have verifiable data on the number of these facilities. However, we have recently received information from a trade association representing physician-owned hospitals that there are approximately 265 hospitals that will be subject to the provisions of our final rule with comment period.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $135 million. This final rule will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications. Because this regulation does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Executive Office of Management and Budget.

XXIII. Interim Final Rule With Comment Period: Certified Registered Nurse Anesthetist (CRNA) Services Furnished in Rural Hospitals and Critical Care Hospitals (CAHs)

A. Background

In the FY 2011 IPPS/LTCH PPS final rule (75 FR 50299), we adopted a policy that would allow otherwise eligible critical access hospitals (CAHs) or hospitals that have reclassified from urban to rural status under section 1886(d)(8)(E) of the Act and 42 CFR 412.103 to receive reasonable cost payments for anesthesia services and related care furnished by nonphysician anesthetists (referred to in this section as CRNA pass-through payments), effective for cost reporting periods beginning on or after October 1, 2010. After the issuance of the final rule, we received an inquiry from a public commenter who indicated that CMS had misunderstood its submitted comment on the FY 2011 IPPS/LTCH PPS proposed rule in which the commenter stated that the policy should be effective on the basis of a calendar year, not a cost reporting period, as a hospital can only begin receiving CRNA pass-through payments on the basis of a calendar year. Our response to this public comment in the CY 2011 IPPS/LTCH PPS final rule (75 FR 50303) indicated that it was unnecessary to modify the effective date in the final rule because "if the provision is effective for cost reporting periods beginning on or after October 1, 2010, it will also be in effect for the calendar year beginning January 1, 2011." While this statement is accurate, it does not take into account that if a hospital's cost reporting period begins on or after January 1, 2011, the hospital will be ineligible to receive CRNA pass-through payments until the beginning of the next calendar year on January 1, 2012. Under the finalized policy in the CY 2011 IPPS/LTCH PPS final rule, hospitals reclassifying from urban to rural areas with cost reporting periods beginning between October 1, 2010, and December 31, 2011, will be able to first receive CRNA pass-through payments effective January 1, 2011, while hospitals with cost reporting periods beginning on or after January 1, 2011, will not be able to receive CRNA pass-through payments until one year later on January 1, 2012.

B. Revised Policy

Our intention in the FY 2011 IPPS/LTCH PPS final rule was not to make the provision for CRNA pass-through payment for anesthesia services and related care furnished by nonphysician anesthetists effective January 1, 2011, for some hospitals and CAHs and January 1, 2012, for other hospitals and CAHs. We believe the provision would be more equitable if it had a uniform effective date for all hospitals and CAHs. While we considered changing the effective date to January 1, 2011, for all hospitals and CAHs to begin receiving CRNA pass-through payments under this provision, we note that our regulations at 42 CFR 412.113(c)(2)(iii) state that the hospital or CAH must demonstrate to its fiscal intermediary prior to the start of the calendar year that it meets the requirements for receiving CRNA pass-through payments. For this reason, we believe the best option would be to adopt an effective date of December 2, 2010, for all hospitals and CAHs, which we are providing for in this interim final rule with comment period. With an effective date of December 2, 2010, hospitals and CAHs will be able to demonstrate prior to January 1, 2011, that they meet the requirements for receiving CRNA pass-

through payments beginning January 1, 2011. We are amending the regulations at 42 CFR 412.113(c)(2)(i)(A) to provide for an effective date of December 2, 2010, for all hospitals and CAHs to begin receiving CRNA pass-through payments for anesthesia services and related care furnished by nonphysician anesthetists.

C. Waiver of Notice of Proposed Rulemaking and Delay in the Effective Date

Because a change to the effective date of a regulation previously adopted through notice-and-comment rulemaking is a substantive change, we would ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule before making any change to the regulation. This procedure can be waived, however, if an agency finds good cause that notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. In addition, the Administrative Procedure Act (APA) normally requires a 30-day delay in the effective date of a final rule. Furthermore, the Congressional Review Act (CRA) generally requires an agency to delay the effective date of a major rule by 60 days in order to allow for congressional review of the agency action.

We believe there is good cause to waive notice-and-comment rulemaking to make a change in the effective date of the CRNA pass-through payment provision adopted in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50414). As stated above, we believe it would be inequitable and contrary to the public interest to have two different effective dates one year apart for hospitals and CAHs depending on when their cost reporting period begins. A change to the effective date will only advantage hospitals and CAHs without disadvantaging any hospital or CAH as it does not affect the ability of hospitals or CAHs with cost reporting periods beginning between October 1, 2010, and December 31, 2010, to begin receiving CRNA pass-through payments on January 1, 2011, and allows hospitals and CAHs with cost reporting periods beginning on any other date to receive CRNA pass-through payments one year earlier. Furthermore, because the purpose of making pass-through payments for CRNA services is to provide more favorable payment treatment for these services in order to improve access to anesthesia services in hospitals and CAHs that are in low population density areas, we believe it would serve the public interest to have this provision apply to all qualifying hospitals and CAHs during 2011, including those hospitals and CAHs that, under the existing regulations, cannot receive CRNA pass-through payments until January 1, 2012. Further, it would be impracticable to go through notice-and-comment rulemaking to achieve what we believe would be the more equitable result because there is insufficient time to complete a proposed rule, allow for a public comment period and prepare a final rule responding to those public comments prior to January 1, 2011, when hospitals and CAHs can next begin receiving CRNA pass-through payments.

For these reasons, in this interim final rule with comment period, we are adopting a change to the effective date of the CRNA pass-through provision originally adopted under § 412.113(c)(2)(i)(A) of the regulations in the FY 2011 IPPS/LTCH PPS final rule for FY 2011 (75 FR 50414) from "cost reporting periods beginning on or after October 1, 2010" to "December 2, 2010." Under this revision, hospitals and CAHs that are reclassified from urban to rural areas can demonstrate to their Medicare contractor on or after December 2, 2010, that they meet the requirements to receive CRNA pass-through payment under § 412.113(c)(2)(iii) in order to begin receiving payments on January 1, 2011.[38] Hospitals and CAHs may receive CRNA pass-through payment for any portion of a cost reporting period that occurs on or after January 1, 2011, provided all other requirements specified in § 412.113(c)(2)(iii) are met.

With respect to a delay in the effective date, this interim final rule with comment period is not a major rule because it does not have an annual effect on the economy of $100 million or more in any 1 year and will not adversely affect in a material way the economy, a section of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal government or communities. As this interim final rule with comment period is not a major rule, we are not required to provide a 60-day delay in its effective date. However, we are providing a 30-day delay in the effective date of this interim final rule with comment period, consistent with the APA. We also are providing a 60-day comment period to receive public comments, as specified in the **ADDRESSES** section of this document.

D. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this document, and, when we proceed with a subsequent document, we will respond to those comments in the preamble to that document.

E. Collection of Information Requirements

This interim final rule with comment period does not impose any new 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. Chapter 35).

F. Regulatory Impact Analysis

We have examined the impact of this interim final rule with comment period as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules that have economically significant effects ($100 million or more in any 1 year) or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal government or communities (58 FR 51741). We have determined that this

[38] The December 2, 2010 effective date is intended to give hospitals and CAHs affected by the change in the effective date sufficient time to demonstrate to their Medicare contractor that they meet the requirements in 42 CFR 412.113(c)(2)(iii) to begin receiving CRNA pass-through payments effective January 1, 2011. If, pursuant to the terms of the existing regulations, hospitals and CAHs have already demonstrated prior to December 2, 2010, that they meet the requirements in § 412.113(c)(2)(iii) to begin receiving CRNA pass-through payments beginning January 1, 2011, they do not have to do so again as they will have already demonstrated prior to the start of the calendar year, consistent with both the existing regulations and the revised regulations, that they meet the requirements for receiving CRNA pass-through payments.

interim final rule with comment period is not a major rule as defined in 5 U.S.C. 804(2).

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals, including CAHs, are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (hospitals having revenues of $34.5 million or less in any 1 year). (For details on the latest standards for health care providers, we refer readers to the SBA's Web site at: *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series).) Individuals and States are not included in the definition of a small entity. For purposes of the RFA, we have determined that most of the affected hospitals and CAHs will be considered small entities according to the SBA size standards.

As discussed above, in this interim final rule with comment period, we are making a revision to the effective date of a change to the CRNA pass-through provision for hospitals and CAHs that have reclassified under section 1886(d)(8)(E) of the Act and § 412.103 of the regulations from "cost reporting periods beginning on or after October 1, 2010" to "December 2, 2010." This change to the effective date will allow hospitals and CAHs that have reclassified under section 1886(d)(8)(E) of the Act and § 412.103 of the regulations to begin receiving CRNA pass-through payments on January 1, 2011, instead of January 1, 2012, if they have a cost reporting period that begins on or after January 1, 2011. (The December 2, 2010 effective date gives these hospitals and CAHs 1 month to demonstrate that they are otherwise eligible to receive these pass-through payments). In the FY 2011 IPPS/LTCH PPS final rule (75 FR 50664), we indicated that it would be difficult to quantify the payment impact of the change to the regulations that would allow hospitals and CAHs reclassified under section 1886(d)(8)(E) of the Act and § 412.103 of the regulations because, in order to qualify to receive reasonable cost-based payment for anesthesia and related services provided by qualified nonphysician anesthetists, a rural hospital or CAH cannot exceed an annual limit of 800 surgical procedures requiring anesthesia. In addition, although a hospital or CAH may contract with more than one qualified nonphysician anesthetist and be paid based on reasonable cost for anesthesia and related services performed by these anesthetists, the total number of hours of services furnished by the nonphysician anesthetists may not exceed 2,080 hours annually. In the final rule, we indicated that we could not establish the number of facilities that would meet or exceed this threshold and, as a result, we could not quantify the impact of the change, but we stated our belief that the impact of the change to the regulations would be expected to be relatively minor. A change to the effective date will only affect a subset of those hospitals and CAHs affected by the change to the regulations adopted in the FY 2010 IPPS/LTCH PPS final rule. For this reason, we would similarly expect the change to the effective date in this interim final rule with comment period to have a minor impact on Federal expenditures.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban areas. Thus, we continue to classify these hospitals as urban hospitals. As this provision will only affect hospitals and CAHs that are geographically located in an urban area, but have reclassified as rural under section 1886(d)(8)(E) of the Act and § 412.103 of the regulations, the change may allow some reclassified small rural hospitals and CAHs to receive CRNA pass-through payments up to 1 year earlier than under the regulations with the prior effective date.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation, by State, local, or tribal governments in the aggregate, or by the private sector. That threshold level is currently approximately $135 million. This interim final rule with comment period will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications. Because this regulation does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget reviewed this interim final rule with comment period.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping requirements.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

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

42 CFR Part 416

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

■ For reasons stated in the preamble of this document, 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 410.2 is amended by—
■ a. Under the definitions of "Community mental health center (CMHC)", removing the word "and" at the end of paragraph (4); removing the period at the end of paragraph (5) and adding in its place "; and"; and adding a new paragraph (6).
■ b. Revising the definition of "Partial hospitalization services".

The revisions and additions read as follows:

§ 410.2 Definitions.

* * * * *

Community mental health center (CMHC) means an entity that—

* * * * *

(6) Provides at least 40 percent of its services to individuals who are not eligible for benefits under title XVIII of the Social Security Act.

* * * * *

Partial hospitalization services means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting and furnishes the services as described in § 410.43.

* * * * *

■ 3. Section 410.27 is amended by—
■ a. Removing the word "and" at the end of paragraph (a)(1)(iii).
■ b. Revising paragraph (a)(1)(iv).
■ c. Adding a new paragraph (a)(1)(v).
■ d. Adding paragraph (a)(2).
■ e. Revising paragraphs (e) and (f).
■ f. Deleting paragraph (g).

The addition and revisions read as follows:

§ 410.27 Outpatient hospital or CAH services and supplies incident to a physician or nonphysician practitioner service: Conditions.

(a) * * *

(1) * * *

(iv) Under the direct supervision of a physician or a nonphysician practitioner as specified in paragraph (f) of this section. Nonphysician practitioners may directly supervise services that they may personally furnish in accordance with State law and all additional requirements, including those specified in §§ 410.71, 410.73, 410.74, 410.75, 410.76, and 410.77. For services furnished in the hospital or CAH, or in an outpatient department of the hospital or CAH, both on and off-campus, as defined in § 413.65 of this subchapter, "direct supervision" means that the physician or nonphysician practitioner must be immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or nonphysician practitioner must be present in the room when the procedure is performed. For pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services, direct supervision must be furnished by a doctor of medicine or osteopathy, as specified in §§ 410.47 and 410.49, respectively; and

(v) As nonsurgical extended duration therapeutic services.

(A) *Nonsurgical extended duration therapeutic services (extended duration services)* are hospital outpatient therapeutic services that can last a significant period of time, have a substantial monitoring component that is typically performed by auxiliary personnel, have a low risk of requiring the physician's or appropriate nonphysician practitioner's immediate availability after the initiation of the service, and are not primarily surgical in nature. For these services, Medicare requires a minimum of direct supervision during the initiation of the service which may be followed by general supervision at the discretion of the supervising physician or the appropriate nonphysician practitioner. For these services, "direct supervision" means the definition specified in paragraph (a)(1)(iv) of this section. "General supervision" means the definition specified at § 410.32(b)(3)(i).

(B) "Initiation" means the beginning portion of the non-surgical extended duration therapeutic service which ends when the patient is stable and the supervising physician or the appropriate nonphysician practitioner believes the remainder of the service can be delivered safely under general supervision.

(2) In the case of partial hospitalization services, also meet the conditions of paragraph (d) of this section.

* * * * *

(e) Services furnished by an entity other than the hospital or CAH are subject to the limitations specified in § 410.42(a).

(f) For purposes of this section, "nonphysician practitioner'" means a clinical psychologist, licensed clinical social worker, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse-midwife.

■ 4. Section 410.28 is amended by revising paragraph (e) to read as follows:

§ 410.28 Hospital or CAH diagnostic services furnished to outpatients: Conditions.

* * * * *

(e) Medicare Part B makes payment under section 1833(t) of the Act for diagnostic services furnished by or under arrangements made by the participating hospital only when the diagnostic services are furnished under the appropriate level of physician supervision specified by CMS in accordance with the definitions in this paragraph and in § 410.32(b)(3)(i), (b)(3)(ii), and (b)(3)(iii). Under general supervision at a facility accorded provider-based status, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the facility. In addition—

(1) For services furnished directly or under arrangement in the hospital or in an on-campus or off-campus outpatient department of the hospital, as defined in § 413.65 of this subchapter, "direct supervision" means that the physician must be immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room where the procedure is performed.

(2) For services furnished under arrangement in nonhospital locations, "direct supervision" means the definition specified in § 410.32(b)(3)(ii).

* * * * *

■ 5. Section 410.152 is amended by revising paragraph (i)(2) to read as follows:

§ 410.152 Amounts of payment.

* * * * *

(i) * * *

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

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

(ii) Between January 1, 2008 and December 31, 2010, Medicare Part B

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

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 6. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh and 1395nn).

■ 7. Section 411.356 is amended by—
■ a. Revising paragraph (c)(1).
■ b. Removing the word "and" at the end of paragraph (c)(3)(ii).
■ c. Removing the period at the end of paragraph (c)(3)(iii) and adding "; and" in its place.
■ d. Adding a new paragraph (c)(3)(iv).

The revisions and addition read as follows:

§ 411.356 Exceptions to the referral prohibition related to ownership or investment interests.

* * * * *

(c) * * *

(1) A rural provider, in the case of DHS furnished in a rural area (as defined at § 411.351 of this subpart) by the provider. A "rural provider" is an entity that furnishes substantially all (not less than 75 percent) of the DHS that it furnishes to residents of a rural area and, for the 18-month period beginning on December 8, 2003 (or such other period as Congress may specify), is not a specialty hospital, and in the case where the entity is a hospital, the hospital meets the requirements of § 411.362 no later than September 23, 2011.

* * * * *

(3) * * *

(iv) The hospital meets the requirements described in § 411.362 not later than September 23, 2011.

■ 8. A new § 411.362 is added to read as follows:

§ 411.362 Additional requirements concerning physician ownership and investment in hospitals.

(a) *Definitions.* For purposes of this section—

Physician owner or investor means a physician (or immediate family member of the physician) with a direct or an indirect ownership or investment interest in the hospital.

Procedure room means a room in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include an emergency room or department (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

(b) *General requirements.*

(1) *Physician ownership and provider agreement.* The hospital had physician ownership or investment on December 31, 2010; and a provider agreement under section 1866 of the Act in effect on that date.

(2) *Prohibition on facility expansion.* The hospital may not increase the number of operating rooms, procedure rooms, and beds beyond that for which the hospital is licensed on March 23, 2010 (or, in the case of a hospital that did not have a provider agreement in effect as of this date, but does have a provider agreement in effect on December 31, 2010, the effective date of such agreement), unless an exception is granted by the Secretary pursuant to section 1877(i)(3) of the Social Security Act.

(3) *Disclosure of conflicts of interest.*

(i) At such time and in such manner as specified by CMS, the hospital must submit an annual report to CMS containing a detailed description of the identity of each owner or investor in the hospital and the nature and extent of all ownership and investment interests in the hospital.

(ii) The hospital must—

(A) Require each referring physician owner or investor who is a member of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to provide written disclosure of his or her ownership or investment interest in the hospital (and, if applicable, the ownership or investment interest of any treating physician) to all patients whom the physician refers to the hospital. Disclosure must be required by a time that permits the patient to make a meaningful decision regarding the receipt of care.

(B) Not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

(C) Disclose on any public Web site for the hospital and in any public advertising that the hospital is owned or invested in by physicians.

(4) *Ensuring bona fide investment.* The hospital satisfies the following criteria:

(i) The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of March 23, 2010.

(ii) Any ownership or investment interests that the hospital offers to a physician owner or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

(iii) The hospital (or any owner or investor in the hospital) does not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor.

(iv) The hospital (or any owner or investor in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

(v) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

(5) *Patient safety.* The hospital satisfies the following criteria:

(i) If the hospital does not have a physician available on the premises to provide services during all hours in which the hospital is providing services to the patient, the hospital must disclose this information to the patient. Before providing services to the patient, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during all hours services are furnished to the patient.

(ii) The hospital must have the capacity to provide assessment and initial treatment for all patients, and the ability to refer and transfer patients to

hospitals with the capability to treat the needs of the patient that the hospital is unable to address. For purposes of this paragraph, the hospital inpatient stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or an outpatient service.

(6) *Prohibition on conversion from an ambulatory surgery center.* The hospital must not have been converted from an ambulatory surgical center to a hospital on or after March 23, 2010.

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 9. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), and sec. 124 of Pub. L. 106–113 (113 Stat. 1501A–332).

■ 10. Section 412.105 is amended by—
■ a. Revising paragraph (f)(1)(ii).
■ b. Revising paragraph (f)(1)(iii)(C).
■ c. Adding a new paragraph (f)(1)(iii)(D).
■ d. Revising paragraph (f)(1)(iv)(B).
■ e. Revising paragraph (f)(1)(iv)(C).
■ f. Revising paragraph (f)(1)(ix).

The revisions and addition read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(f) * * *

(1) * * *

(ii) In order to be counted, the resident must be assigned to one of the following areas:

(A) The portion of the hospital subject to the hospital inpatient prospective payment system.

(B) The outpatient department of a hospital that meets provider-based status as defined at § 413.65(a)(2) of this subchapter.

(C) The portions of a hospital located in Puerto Rico that are subject to the hospital inpatient prospective payment system, including off-campus outpatient departments that meet provider-based status as defined at § 413.65(a)(2) of this subchapter.

(D) The portions of a hospital that are reimbursed under a reimbursement system authorized under section 1814(b)(3) of the Act.

(E) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonprovider setting in patient care activities, as defined in § 413.75(b) of this subchapter, under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth in § 413.78(c), (d), (e), (f), or (g) of this subchapter, as applicable, are met.

(iii) * * *

(C) Effective for cost reporting periods beginning on or after January 1, 1983, except for research activities described in paragraph (f)(1)(iii)(B) of this section, the time a resident is training in an approved medical residency program in a hospital setting, as described in paragraphs (f)(1)(ii)(A) through (f)(1)(ii)(D) of this section, must be spent in either patient care activities, as defined in § 413.75(b) of this subchapter, or in nonpatient care activities, such as didactic conferences and seminars, to be counted. This provision may not be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which, as of March 23, 2010, there is a jurisdictionally proper appeal pending on direct GME or IME payments.

(D) Effective for cost reporting periods beginning on or after January 1, 1983, the time spent by a resident in an approved medical residency program on vacation, sick leave, or other approved leave that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program is countable. This provision may not be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which, as of March 23, 2010, there is a jurisdictionally proper appeal pending on direct GME or IME payments.

(iv) * * *

(B)(*1*) Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital's otherwise applicable FTE resident cap may be reduced if its reference resident level, as determined under § 413.79(c)(1)(ii)(A) of this subchapter, is less than its otherwise applicable FTE resident cap in a reference cost reporting period, in accordance with the provisions of § 413.79(c)(3) of this subchapter. The reduction is 75 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level.

(*2*) Effective for portions of cost reporting periods beginning on or after July 1, 2011, a hospital's otherwise applicable FTE resident cap may be reduced if its reference resident level, as determined under § 413.79(c)(1)(ii)(B) of this subchapter, is less than its otherwise applicable FTE resident cap in a reference cost reporting period, in accordance with the provisions of § 413.79(m) of this subchapter. The reduction shall take into account the hospital's FTE resident cap as reduced under paragraph (f)(1)(iv)(B)(*1*). The reduction is 65 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level.

(C)(*1*) Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital may qualify to receive an increase in its otherwise applicable FTE resident cap (up to 25 additional FTEs) if the criteria specified in § 413.79(c)(4) of this subchapter are met.

(*2*) Effective for portions of cost reporting periods beginning on or after July 1, 2011, a hospital may qualify to receive an increase in its otherwise applicable FTE resident cap (up to 75 additional FTEs) if the criteria specified in § 413.79(n) of this subchapter are met.

* * * * *

(ix)(A) A hospital may receive a temporary adjustment to its FTE resident cap to reflect residents added because of another hospital's closure if the hospital meets the criteria specified in §§ 413.79(h)(1) and (h)(2) of this subchapter. If a hospital that closes its residency training program agrees to temporarily reduce its FTE resident cap according to the criteria specified in §§ 413.79(h)(1) and (h)(3)(ii) of this subchapter, another hospital(s) may receive a temporary adjustment to its FTE resident cap to reflect residents added because of the closure of the residency training program if the criteria specified in §§ 413.79(h)(1) and (h)(3)(i) of this subchapter are met.

(B) A hospital may receive a permanent adjustment to its FTE resident cap as a result of slots that were redistributed from a closed hospital, as defined at § 413.79(h)(1)(i) of this subchapter, if the hospital meets the requirements at § 413.79(o) of this subchapter.

* * * * *

■ 11. Section 412.113 is amended by revising paragraph (c)(2)(i)(A) to read as follows:

§ 412.113 Other payments.

* * * * *

(c) * * *

(2)(i) * * *

(A) The hospital or CAH is located in a rural area as defined in § 412.62(f) and is not deemed to be located in an urban area under the provisions of § 412.64(b)(3). Effective December 2, 2010, the hospital or CAH is either located in a rural area as defined at

§ 412.62(f) and is not deemed to be located in an urban area under the provisions of § 412.64(b)(3) or the hospital or CAH has reclassified as rural under the provisions at § 412.103.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

■ 12. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Pub. L. 106–133 (113 Stat. 1501A–332).

■ 13. Section 413.75 is amended by—

■ a. Revising paragraph (2) of the definition of "All or substantially all of the costs for the training program in the nonhospital setting".

■ b. Adding a definition of "Nonprovider setting that is primarily engaged in furnishing patient care".

The revision and addition read as follows:

§ 413.75 Direct GME payments: General requirements.

* * * * *

(b) * * *

All or substantially all of the costs for the training program in the nonhospital setting means—

* * * * *

(2) Effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to nonpatient care direct GME activities.

* * * * *

Nonprovider setting that is primarily engaged in furnishing patient care means a nonprovider setting in which the primary activity is the care and treatment of patients.

* * * * *

■ 14. Section 413.78 is amended by—

■ a. Revising the introductory text of paragraph (f).

■ b. Revising paragraph (f)(1).

■ c. Adding a new paragraph (g).

■ d. Adding a new paragraph (h).

The revisions and additions read as follows:

§ 413.78 Direct GME payments: Determination of the total number of FTE residents.

* * * * *

(f) For cost reporting periods beginning on or after July 1, 2007, and before July 1, 2010, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities as defined at § 413.75(b), except that for cost reporting periods beginning on or after July 1, 2009, the time spent training in nonpatient care activities, such as didactic conferences and seminars, but excluding research not associated with the treatment or diagnosis of a particular patient, in a nonprovider setting that is primarily engaged in furnishing patient care activities, as defined at § 413.75(b), also may be counted.

* * * * *

(g) For cost reporting periods beginning on or after July 1, 2010, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time—

(i) In patient care activities as defined at § 413.75(b); or

(ii) In nonpatient care activities, such as didactic conferences and seminars, but excluding research not associated with the treatment or diagnosis of a particular patient, in a nonprovider setting that is primarily engaged in furnishing patient care activities, as defined at § 413.75(b).

(2) The hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting. If more than one hospital incurs these costs, either directly or through a third party, the hospitals must count a proportional share of the time that residents train at the nonhospital setting(s) as recorded in a written agreement between the hospitals.

(i) Hospitals must have a reasonable basis for establishing that proportion of the cost and the FTE time that each will incur and count.

(ii) If hospitals already arrange payment to the nonhospital site via a written agreement as described in paragraph (g)(3)(ii) of this section, the proportion may be recorded in that agreement.

(iii) If hospitals choose to pay the nonhospital site concurrently as described in paragraph (g)(3)(i) of this section, the hospitals must record the proportion of cost and FTE time they are incurring and counting in a written agreement between the hospitals.

(3) The hospital or hospitals must comply with one of the following:

(i) The hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting by the end of the third month following the month in which the training in the nonhospital site occurred.

(ii) There is a written agreement between the hospital or hospitals and the outside entity that states that the residents' salaries and fringe benefits (including travel and lodging where applicable) during the time the resident spends in the nonhospital setting is to be paid by the hospital(s). Hospitals may modify the amounts specified in the written agreement by the end of the academic year (that is, June 30) to reflect that the costs of the training program in the nonhospital site have been incurred.

(4) The hospital is subject to the principles of community support and redistribution of costs as specified in § 413.81.

(5) For cost reporting periods beginning on or after July 1, 2010, a hospital must maintain and make available records of the FTE count determined for direct GME purposes under this section that its residents spend in nonprovider sites, in order to compare that time to the time spent by its residents in nonprovider sites in the base year of cost reporting periods beginning on or after July 1, 2009, and before June 30, 2010. The hospital must supply the CMS contractor with the data for each of its primary care programs on a program-specific basis, and with data for its nonprimary care programs on an overall basis.

(6) The provisions of paragraphs (g)(1)(ii), (g)(2), (g)(3), and (g)(5) of this section cannot be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which there is a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.

(h) Effective for cost reporting periods beginning on or after January 1, 1983, the time spent by a resident in an approved medical residency program on vacation, sick leave, or other approved leave that does not prolong the total

time the resident is participating in the approved program beyond the normal duration of the program is countable. This provision cannot be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which there is a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.

■ 15. Section 413.79 is amended by—
■ a. Revising paragraph (c)(1)(ii).
■ b. Revising the introductory text of paragraph (c)(2).
■ c. Revising paragraph (c)(2)(iv).
■ d. Revising the heading of paragraph (c)(3).
■ e. Revising the heading of paragraph (c)(4).
■ f. Revising the heading of paragraph (c)(5).
■ g. Revising paragraph (d)(6).
■ i. Adding a new paragraph (m).
■ j. Adding a new paragraph (n).
■ k. Adding a new paragraph (o).

The revisions and additions read as follows:

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

* * * * *

(c) * * *

(1) * * *

(ii)(A) For purposes of paragraph (c)(3) of this section, *reference resident level* refers to a hospital's resident level in the applicable reference period specified under paragraph (c)(3) of this section.

(B) For purposes of paragraph (m) of this section, *reference resident level* means with respect to a hospital, the highest resident level for any of the three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been either settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010.

* * * * *

(2) *Determination of the FTE resident cap.* Subject to the provisions of paragraphs (c)(3) through (c)(6) and (m) through (o) of this section and § 413.81, for purposes of determining direct GME payment—

* * * * *

(iv) Hospitals that are part of the same Medicare GME affiliated group or the same emergency Medicare GME affiliated group (as described under § 413.75(b)) may elect to apply the limit on an aggregate basis as described under paragraph (f) of this section.

* * * * *

(3) *Determination of the reduction to the FTE resident cap due to unused FTE resident slots under section 422 of Public Law 108–173.* * * *

(4) *Determination of an increase in the otherwise applicable resident cap under section 422 of Public Law 108–173.* * * *

(5) *Special rules for hospitals that participate in demonstration projects or voluntary resident reduction plans for purposes of section 422 of Public Law 108–173.* * * *

(d) * * *

(6)(i) Subject to the provisions of paragraph (h) of this section, FTE residents who are displaced by the closure of either another hospital or another hospital's program are added to the FTE count after applying the averaging rules in this paragraph (d), for the receiving hospital for the duration of the time that the displaced residents are training at the receiving hospital.

(ii) If a hospital receives a permanent increase in its FTE resident cap under paragraph (o)(1) of this section due to redistribution of slots from a closed hospital, the displaced FTE residents that the hospital receives are added to the FTE count after applying the averaging rules only in the first cost reporting period in which the receiving hospital trains the displaced FTE residents. In subsequent cost reporting periods, the displaced FTE residents are included in the receiving hospital's rolling average calculation.

* * * * *

(m) *Determination of the reduction to the FTE resident cap due to unused FTE resident slots under section 5503 of Public Law 111–148.* If a hospital's reference resident level, as defined under paragraph (c)(1)(ii)(B) of this section is less than its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section or paragraph (e) of this section in the reference cost reporting period (as described under paragraph (m)(6) of this section), for portions of cost reporting periods beginning on or after July 1, 2011, the hospital's otherwise applicable FTE resident cap is reduced by 65 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level. The reduction shall take into account the hospital's FTE resident cap as reduced under paragraph (c)(3) of this section. Under this provision—

(1) *Exemption for certain rural hospitals.* A rural hospital, as defined at subpart D of Part 412 of this subchapter, with fewer than 250 beds (as determined at § 412.105(b)) in its most recent cost reporting period ending on or before March 23, 2010, for which a cost report has been either settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(2) *Exemption for certain hospitals that participate in demonstration projects or voluntary residency reduction plans.* A hospital that was participating in a demonstration project under section 402 of Public Law 90–248 or the voluntary reduction plan under § 413.88, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section if, by January 21, 2011, it submits a plan to CMS for filling all of its unused FTE resident slots by not later than March 23, 2012.

(3) *Exemption for a hospital described at section 1886(h)(4)(H)(v) of the Act.* A hospital described at section 1886(h)(4)(H)(v) of the Act, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(4) *Exemptions for certain other hospitals.* A hospital training at or above its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section for all three most recent cost reporting periods ending prior to March 23, 2010, for which a cost report has been either settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(5) *New teaching hospital.* A new teaching hospital that does not have an otherwise applicable FTE resident cap as determined under paragraph (e)(1) of this section for all three most recent cost reporting periods ending prior to March 23, 2010, for which a cost report has been either settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(6) *Reference cost reporting period.* (i) To determine a hospital's reference resident level, CMS determines, for a hospital's three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been either settled or submitted (subject to audit) to the Medicare contractor by March 23, 2010, the cost reporting period with the highest resident level.

(ii) If the cost report that is used to determine a hospital's otherwise applicable FTE resident cap in the reference period is not equal to 12 months, the Medicare contractor may make appropriate modifications to apply the provisions of paragraph (m) of this section based on the equivalent of a 12-month cost reporting period.

(7) *Affiliated cap.* If a hospital is a member of a Medicare GME affiliated group during its reference cost reporting period, and its reference resident level is less than its otherwise applicable FTE resident cap as adjusted by the terms of the Medicare GME affiliation agreement, the hospital's FTE resident cap will be reduced by 65 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level. The reduction will take into account the hospital's FTE resident cap as reduced under the provisions of paragraph (c)(3) of this section.

(n) *Determination of an increase in the otherwise applicable resident cap under section 5503 of Public Law 111–148.* (1) For portions of cost reporting periods beginning on or after July 1, 2011, a hospital may receive an increase in its otherwise applicable FTE resident cap (as determined by CMS) of not more than 75 additional FTEs if the hospital meets the requirements and qualifying criteria of section 1886(h)(8) of the Act and implementing instructions issued by CMS and if the hospital submits an application to CMS within the timeframe specified by CMS.

(2) A hospital that receives an increase in the otherwise applicable FTE resident cap under paragraph (n)(1) of this section must ensure, during the 5-year period beginning on July 1, 2011 and ending on June 30, 2016, that—

(i) The number of FTE primary care residents, as defined in § 413.75(b), excluding any additional positions under this paragraph, is not less than the average number of FTE primary care residents (as so determined) during the three most recent cost reporting periods ending prior to March 23, 2010 (and submitted to the Medicare contractor by March 23, 2010); and not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency programs.

(ii) CMS may determine whether a hospital has met the requirements under paragraph (n)(1) of this section during the 5-year period of July 1, 2011 through June 30, 2016, in such manner and at such time as CMS determines appropriate, including at the end of such 5-year period.

(iii) In a case where the Medicare contractor determines that a hospital did not meet the requirements in a cost reporting period within the 5-year time period, the Medicare contractor will reduce the otherwise applicable FTE resident cap of the hospital by the amount by which such limit was increased under paragraph (n)(1) of this section from the earliest cost reporting period that is reopenable in which it would be determined that the hospital did not meet the requirements.

(o) *Determination of an increase in the FTE resident cap due to slots redistributed from a closed hospital.* (1) Except in the case of the closure of the hospital with Medicare Provider Number 05–0578, in the instance of a hospital closure, as defined at paragraph (h)(1)(i) of this section, the FTE resident cap of the closed hospital would be redistributed, and a hospital that meets the requirements and qualifying criteria of section 1886(h)(4)(H)(vi) of the Act and implementing instructions issued by CMS, including submission of a timely application to CMS, may receive an increase in its FTE resident cap, as determined by CMS.

(2)(i) Except in the case of the closure of the hospital with Medicare Provider Number 05–0578, in redistributing the FTE resident cap of a closed hospital, consideration shall be given to ensure that there is no duplication of FTE slots between FTE slots redistributed under this paragraph and temporary adjustments to FTE resident caps provider under paragraph (h)(2) of this section.

(ii) The provisions of this paragraph (o) will not be applied in a manner that will require the reopening of settled cost reports, except where the provider has a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.

PART 416—AMBULATORY SURGICAL SERVICES

■ 16. 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).

■ 17. Section 416.160 is amended by—
■ a. Revising paragraph (a)(1).
■ b. Revising paragraph (a)(4).
■ c. Adding a new paragraph (a)(5).

The revisions and addition read as follows:

§ 416.160 Basis and scope.

(a) * * *

(1) Section 1833(i)(2)(D) of the Act requires the Secretary to implement a revised payment system for payment of surgical services furnished in ASCs. The statute requires that, in the year such system is implemented, the system shall be designed to result in the same amount of aggregate expenditures for such services as would be made if there was no requirement for a revised payment system. The revised payment system shall be implemented no earlier than January 1, 2006, and no later than January 1, 2008. The statute also requires that, for CY 2011 and each subsequent year, any annual update to the ASC payment system be reduced by a productivity adjustment. There shall be no administrative or judicial review under section 1869 of the Act, section 1878 of the Act, or otherwise of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, of the revised payment system.

* * * * *

(4) Section 1834(d) of the Act specifies that, when screening colonoscopies or screening flexible sigmoidoscopies are performed in an ASC or hospital outpatient department, payment shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area. Section 1834(d) of the Act also specifies that, in the case of screening flexible sigmoidoscopy and screening colonoscopy services, the payment amounts must not exceed the payment rates established for the related diagnostic services.

(5) Section 1833(a)(1) of the Act requires 100 percent payment for preventive services described in section 1861(ww)(2) of the Act (excluding electrocardiograms) to which the United States Preventive Services Task Force (USPSTF) has given a grade of A or B for any indication or population. Section 1833(b)(1) of the Act also specifies that the Part B deductible shall not apply with respect to preventive services described in section 1861(ww)(2) of the Act (excluding electrocardiograms) to which the USPSTF has given a grade of A or B for any indication or population.

* * * * *

■ 18. Section 416.171 is amended by adding a new paragraph (a)(2)(iii) to read as follows:

§ 416.171 Determination of payment rates for ASC services.

(a) * * *

(2) * * *

(iii) *Productivity adjustment.* (A) For calendar year 2011 and subsequent years, the Consumer Price Index for All Urban Consumers determined under paragraph (a)(2)(ii) of this section is reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

(B) The application of the provisions of paragraph (a)(2)(iii)(A) of this section may result in the update being less than

0.0 for a year, and may result in payment rates for a year being less than the payment rates for the preceding year.

* * * * *

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

■ 19. The authority citation for part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395(t), and 1395hh).

■ 20. Section 419.21 is amended by revising paragraph (e) to read as follows:

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

* * * * *

(e)(1) Effective January 1, 2005 through December 31, 2008, an initial preventive physical examination, as defined in § 410.16 of this chapter, if the examination is performed no later than 6 months after the individual's initial Part B coverage date that begins on or after January 1, 2005.

(2) Effective January 1, 2009, an initial preventive physical examination, as defined in § 410.16 of this chapter, if the examination is performed no later than 12 months after the date of the individual's initial enrollment in Part B.

■ 21. Section 419.22 is amended by—

■ a. Revising paragraph (m).

■ b. Adding a new paragraph (t).

The revision and addition read as follows:

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

* * * * *

(m)(1) Services provided on or before December 31, 2010, for patients with ESRD that are paid under the ESRD composite rate and drugs and supplies furnished during dialysis but not included in the composite rate.

(2) Renal dialysis services provided on or after January 1, 2011, for patients with ESRD that are paid under the ESRD benefit, as described in Subpart H of Part 413 of this chapter.

* * * * *

(t) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in § 410.15 of this chapter.

■ 22. Section 419.32 is amended by revising paragraph (b)(1)(iv) to read as follows:

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

* * * * *

(b) * * *

(1) * * *

(iv)(A) For calendar year 2003 and subsequent years, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

(B) The percentage increase determined under paragraph (b)(1)(iv)(A) of this section is reduced by the following for the specific calendar year:

(*1*) For calendar year 2010, 0.25 percentage point; and

(*2*) For calendar year 2011, 0.25 percentage point.

* * * * *

■ 23. Section 419.43 is amended by revising paragraph (c) to read as follows:

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

* * * * *

(c) *Wage index factor.*—(1) CMS uses the hospital inpatient prospective payment system wage index established in accordance with Part 412 of this chapter to make the adjustment specified under paragraph (a) of this section.

(2) For services furnished beginning January 1, 2011, the wage index factor provided for in paragraph (c)(1) of this section applicable to any hospital outpatient department that is located in a frontier State, as defined in § 412.64(m) of this chapter, may not be less than 1.00.

(3) The additional payments made under the provisions of paragraph (c)(2) of this section are not implemented in a budget neutral manner.

* * * * *

■ 24. Section 419.70 is amended by—

■ a. Revising paragraph (d)(2) introductory text.

■ b. Adding a new paragraph (d)(6).

The revision and addition read as follows.

§ 419.70 Transitional adjustments to limit decline in payments.

* * * * *

(d) * * *

(2) *Temporary treatment for small rural hospitals on or after January 1, 2006.* For covered hospital outpatient services furnished in a calendar year from January 1, 2006, through December 31, 2010, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by 95 percent of that difference for services furnished during 2006, 90 percent of that difference for services furnished during 2007, and 85 percent of that difference for services furnished during 2008, 2009, and 2010, if the hospital—

* * * * *

(6) *Temporary treatment for sole community hospitals on or after January 1, 2010, and through December 31, 2010.* For covered hospital outpatient services furnished on or after January 1, 2010 through December 31, 2010, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by 85 percent of that difference if the hospital is a sole community hospital as defined in § 412.92 of this chapter or is an essential access community hospital as described under § 412.109 of this chapter.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

■ 25. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

■ 26. Section 489.20 is amended by revising paragraph (w) to read as follows:

§ 489.20 Basic commitments.

* * * * *

(w)(1) In the case of a hospital as defined in § 489.24(b), to furnish written notice to all patients at the beginning of their hospital stay or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week, in order to assist the patients in making informed decisions regarding their care, in accordance with § 482.13(b)(2) of this subchapter. The notice must indicate how the hospital will meet the medical needs of any patient who develops an emergency medical condition, as defined in § 489.24(b), at a time when there is no physician present in the hospital. For purposes of this paragraph, the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or outpatient service.

(2) Before admitting a patient or providing an outpatient service, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during

all hours services are furnished to the patient.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; Program No. 93.774, Medicare—Supplementary Medical Insurance Program; and Program No. 93.778 (Medical Assistance))

Dated: October 26, 2010.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 29, 2010.

Kathleen Sebelius,

Secretary.

Note: The following addenda will not appear in the Code of Federal Regulations:

BILLING CODE 4120–01–P

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001	Level I Photochemotherapy	S	0.5543	$38.18	.	$7.64
0002	Fine Needle Biopsy/Aspiration	T	1.5703	$108.16	.	$21.64
0003	Bone Marrow Biopsy/Aspiration	T	3.7390	$257.53	.	$51.51
0004	Level I Needle Biopsy/Aspiration Except Bone Marrow	T	4.5843	$315.75	.	$63.15
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	8.1362	$560.39	.	$112.08
0006	Level I Incision & Drainage	T	1.4906	$102.67	.	$20.54
0007	Level II Incision & Drainage	T	13.0129	$896.28	.	$179.26
0008	Level III Incision and Drainage	T	20.1996	$1,391.27	.	$278.26
0012	Level I Debridement & Destruction	T	0.4326	$29.80	.	$5.96
0013	Level II Debridement & Destruction	T	0.9103	$62.70	.	$12.54
0015	Level III Debridement & Destruction	T	1.4975	$103.14	.	$20.63
0016	Level IV Debridement & Destruction	T	2.7318	$188.16	.	$37.64
0017	Level V Debridement & Destruction	T	21.7969	$1,501.28	.	$300.26
0019	Level I Excision/ Biopsy	T	5.0887	$350.49	.	$70.10
0020	Level II Excision/ Biopsy	T	8.4929	$584.96	.	$117.00
0021	Level III Excision/ Biopsy	T	18.0784	$1,245.17	.	$249.04
0022	Level IV Excision/ Biopsy	T	23.8986	$1,646.04	$354.45	$329.21
0028	Level I Breast Surgery	T	25.5910	$1,762.61	.	$352.53
0029	Level II Breast Surgery	T	33.9253	$2,336.64	$581.52	$467.33
0030	Level III Breast Surgery	T	45.0028	$3,099.61	$747.07	$619.93
0031	Smoking Cessation Services	X	0.3010	$20.73	.	$4.15
0034	Mental Health Services Composite	S	3.4603	$238.33	.	$47.67
0035	Vascular Puncture and Minor Diagnostic Procedures	X	0.2674	$18.42	.	$3.69
0037	Level IV Needle Biopsy/Aspiration Except Bone Marrow	T	15.7009	$1,081.42	$228.76	$216.29
0039	Level I Implantation of Neurostimulator Generator	S	214.0597	$14,743.58	.	$2,948.72
0040	Percutaneous Implantation of Neurostimulator Electrodes	S	66.1046	$4,553.02	.	$910.61
0041	Level I Arthroscopy	T	29.9672	$2,064.02	.	$412.81
0042	Level II Arthroscopy	T	48.4428	$3,336.55	$804.74	$667.31
0045	Bone/Joint Manipulation Under Anesthesia	T	15.5512	$1,071.10	$268.44	$214.22
0047	Arthroplasty without Prosthesis	T	39.2855	$2,705.83	.	$541.17
0048	Level I Arthroplasty or Implantation with Prosthesis	T	59.9568	$4,129.58	.	$825.92
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.9744	$1,582.38	.	$316.48

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	32.2439	$2,220.83	.	$444.17
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	47.3213	$3,259.30	.	$651.86
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	88.9869	$6,129.06	.	$1,225.82
0053	Level I Hand Musculoskeletal Procedures	T	17.1642	$1,182.20	$253.49	$236.44
0054	Level II Hand Musculoskeletal Procedures	T	29.7686	$2,050.34	.	$410.07
0055	Level I Foot Musculoskeletal Procedures	T	22.5951	$1,556.26	$355.34	$311.26
0056	Level II Foot Musculoskeletal Procedures	T	55.2578	$3,805.94	.	$761.19
0057	Bunion Procedures	T	33.2448	$2,289.77	$475.91	$457.96
0058	Level I Strapping and Cast Application	S	1.1201	$77.15	.	$15.43
0060	Manipulation Therapy	S	0.2864	$19.73	.	$3.95
0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	S	90.0429	$6,201.79	.	$1,240.36
0062	Level I Treatment Fracture/Dislocation	T	26.5543	$1,828.95	$372.87	$365.79
0063	Level II Treatment Fracture/Dislocation	T	48.1318	$3,315.13	.	$663.03
0064	Level III Treatment Fracture/Dislocation	T	66.9057	$4,608.20	.	$921.64
0065	Level I Stereotactic Radiosurgery, MRgFUS, and MEG	S	14.1866	$977.12	.	$195.43
0066	Level II Stereotactic Radiosurgery, MRgFUS, and MEG	S	36.3649	$2,504.67	.	$500.94
0067	Level III Stereotactic Radiosurgery, MRgFUS, and MEG	S	49.4903	$3,408.69	.	$681.74
0069	Thoracoscopy	T	34.8422	$2,399.79	$591.64	$479.96
0070	Thoracentesis/Lavage Procedures	T	5.5631	$383.16	.	$76.64
0071	Level I Endoscopy Upper Airway	T	0.9297	$64.03	.	$12.81
0072	Level II Endoscopy Upper Airway	T	2.0114	$138.54	.	$27.71
0073	Level III Endoscopy Upper Airway	T	4.2250	$291.00	$67.83	$58.20
0074	Level IV Endoscopy Upper Airway	T	21.9448	$1,511.47	.	$302.30
0075	Level V Endoscopy Upper Airway	T	30.9463	$2,131.46	$445.92	$426.30
0076	Level I Endoscopy Lower Airway	T	10.5006	$723.24	$189.82	$144.65
0077	Level I Pulmonary Treatment	S	0.4171	$28.73	$7.74	$5.75
0078	Level III Pulmonary Treatment	S	1.4318	$98.62	.	$19.73
0079	Ventilation Initiation and Management	S	2.9048	$200.07	.	$40.02
0080	Diagnostic Cardiac Catheterization	T	39.5907	$2,726.85	$838.92	$545.37
0082	Coronary or Non-Coronary Atherectomy	T	92.7252	$6,386.54	.	$1,277.31
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty	T	54.8838	$3,780.18	.	$756.04
0084	Level I Electrophysiologic Procedures	S	10.3020	$709.56	.	$141.92
0085	Level II Electrophysiologic Procedures	T	53.6428	$3,694.70	.	$738.94

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0086	Level III Electrophysiologic Procedures	T	122.6468	$8,447.42	.	$1,689.49
0088	Thrombectomy	T	41.7208	$2,873.56	$655.22	$574.72
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	113.4179	$7,811.77	$1,643.98	$1,562.36
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	95.5918	$6,583.98	$1,593.50	$1,316.80
0091	Level II Vascular Ligation	T	43.9936	$3,030.10	.	$606.02
0092	Level I Vascular Ligation	T	27.4530	$1,890.85	.	$378.17
0093	Vascular Reconstruction/Fistula Repair without Device	T	36.4868	$2,513.06	.	$502.62
0094	Level I Resuscitation and Cardioversion	S	2.3671	$163.04	$45.71	$32.61
0095	Cardiac Rehabilitation	S	0.9991	$68.81	$13.86	$13.77
0096	Level II Noninvasive Physiologic Studies	S	1.5460	$106.48	$36.86	$21.30
0097	Level I Noninvasive Physiologic Studies	S	0.9619	$66.25	$23.79	$13.25
0099	Electrocardiograms/Cardiography	S	0.3958	$27.26	.	$5.46
0100	Cardiac Stress Tests	X	2.5904	$178.42	$41.44	$35.69
0101	Tilt Table Evaluation	S	4.2671	$293.90	$100.24	$58.78
0102	Level II Pulmonary Treatment	S	0.9144	$62.98	.	$12.60
0103	Miscellaneous Vascular Procedures	T	19.1361	$1,318.02	.	$263.61
0104	Transcatheter Placement of Intracoronary Stents	T	82.1118	$5,655.53	.	$1,131.11
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices	T	22.7342	$1,565.84	.	$313.17
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	T	52.2139	$3,596.28	.	$719.26
0107	Insertion of Cardioverter-Defibrillator	T	339.8079	$23,404.61	.	$4,680.93
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	389.5350	$26,829.61	.	$5,365.93
0110	Transfusion	S	3.3918	$233.61	.	$46.73
0111	Blood Product Exchange	S	12.3872	$853.18	$198.40	$170.64
0112	Apheresis and Stem Cell Procedures	S	31.4526	$2,166.33	.	$433.27
0113	Excision Lymphatic System	T	25.0607	$1,726.08	.	$345.22
0114	Thyroid/Lymphadenectomy Procedures	T	50.7814	$3,497.62	.	$699.53
0115	Cannula/Access Device Procedures	T	35.0863	$2,416.60	.	$483.32
0121	Level I Tube or Catheter Changes or Repositioning	T	6.3298	$435.97	.	$87.20
0126	Level I Urinary and Anal Procedures	T	1.1110	$76.52	$16.21	$15.31
0127	Level IV Stereotactic Radiosurgery, MRgFUS, and MEG	S	111.2310	$7,661.15	.	$1,532.23
0128	Echocardiogram with Contrast	S	7.2453	$499.03	$166.16	$99.81
0129	Level I Closed Treatment Fracture Finger/Toe/Trunk	T	1.5787	$108.73	.	$21.75

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0130	Level I Laparoscopy	T	38.6514	$2,662.15	$659.53	$532.43
0131	Level II Laparoscopy	T	47.8453	$3,295.39	$1,001.89	$659.08
0132	Level III Laparoscopy	T	71.0980	$4,896.95	$1,236.99	$979.39
0133	Level I Skin Repair	T	1.3330	$91.81	$25.67	$18.37
0134	Level II Skin Repair	T	3.1618	$217.77	.	$43.56
0135	Level III Skin Repair	T	4.6422	$319.74	.	$63.95
0136	Level IV Skin Repair	T	17.2117	$1,185.47	.	$237.10
0137	Level V Skin Repair	T	22.2821	$1,534.70	.	$306.94
0138	Level II Closed Treatment Fracture Finger/Toe/Trunk	T	5.5050	$379.16	.	$75.84
0139	Level III Closed Treatment Fracture Finger/Toe/Trunk	T	20.8356	$1,435.07	.	$287.02
0140	Esophageal Dilation without Endoscopy	T	6.5637	$452.08	.	$90.42
0141	Level I Upper GI Procedures	T	8.8816	$611.73	$143.38	$122.35
0142	Small Intestine Endoscopy	T	10.1857	$701.55	$152.78	$140.31
0143	Lower GI Endoscopy	T	9.3416	$643.41	$186.06	$128.69
0146	Level I Sigmoidoscopy and Anoscopy	T	5.7982	$399.36	.	$79.88
0147	Level II Sigmoidoscopy and Anoscopy	T	9.5044	$654.63	.	$130.93
0148	Level I Anal/Rectal Procedures	T	6.0158	$414.34	.	$82.87
0149	Level III Anal/Rectal Procedures	T	24.3450	$1,676.79	.	$335.36
0150	Level IV Anal/Rectal Procedures	T	32.6594	$2,249.45	.	$449.89
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	23.2357	$1,600.38	.	$320.08
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	31.7356	$2,185.82	.	$437.17
0153	Peritoneal and Abdominal Procedures	T	26.4829	$1,824.04	$375.24	$364.81
0154	Hernia/Hydrocele Procedures	T	33.0791	$2,278.36	$464.85	$455.68
0155	Level II Anal/Rectal Procedures	T	16.1126	$1,109.77	.	$221.96
0156	Level III Urinary and Anal Procedures	T	3.2116	$221.20	.	$44.24
0157	Colorectal Cancer Screening: Barium Enema	S	1.2404	$85.43	.	$17.09
0158	Colorectal Cancer Screening: Colonoscopy	T	8.2742	$569.89	$0.00	$0.00
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	5.5084	$379.40	$0.00	$0.00
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	7.4406	$512.48	.	$102.50
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	17.5738	$1,210.41	.	$242.09
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	26.3334	$1,813.74	.	$362.75
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	37.3582	$2,573.08	.	$514.62

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0164	Level II Urinary and Anal Procedures	T	2.0369	$140.29	.	$28.06
0165	Level IV Urinary and Anal Procedures	T	20.0886	$1,383.62	.	$276.73
0166	Level I Urethral Procedures	T	21.6923	$1,494.08	.	$298.82
0168	Level II Urethral Procedures	T	32.6605	$2,249.52	.	$449.91
0169	Lithotripsy	T	41.9797	$2,891.39	$997.74	$578.28
0170	Dialysis	S	6.9317	$477.43	.	$95.49
0172	Level I Partial Hospitalization (3 services) for CMHCs	P	1.8822	$129.64	.	$25.93
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	P	2.3873	$164.43	.	$32.89
0174	Level IV Laparoscopy	T	113.9757	$7,850.19	$2,064.24	$1,570.04
0175	Level I Partial Hospitalization (3 services) for Hospital-based PHPs	P	2.9747	$204.89	.	$40.98
0176	Level II Partial Hospitalization (4 or more services) for Hospital-based PHPs	P	3.4603	$238.33	.	$47.67
0181	Level II Male Genital Procedures	T	35.9464	$2,475.84	$620.84	$495.17
0183	Level I Male Genital Procedures	T	23.7359	$1,634.83	.	$326.97
0184	Prostate Biopsy	T	13.0286	$897.36	.	$179.48
0188	Level II Female Reproductive Proc	T	1.6350	$112.61	.	$22.53
0189	Level III Female Reproductive Proc	T	3.6204	$249.36	.	$49.88
0190	Level I Hysteroscopy	T	23.0829	$1,589.86	$424.28	$317.98
0191	Level I Female Reproductive Proc	T	0.1446	$9.96	$2.08	$2.00
0192	Level IV Female Reproductive Proc	T	6.5660	$452.24	.	$90.45
0193	Level V Female Reproductive Proc	T	20.6779	$1,424.21	.	$284.85
0195	Level VI Female Reproductive Procedures	T	35.6739	$2,457.08	.	$491.42
0202	Level VII Female Reproductive Procedures	T	45.3938	$3,126.54	$981.50	$625.31
0203	Level IV Nerve Injections	T	12.7951	$881.28	.	$176.26
0204	Level I Nerve Injections	T	2.6683	$183.78	$40.13	$36.76
0206	Level II Nerve Injections	T	3.8823	$267.40	.	$53.48
0207	Level III Nerve Injections	T	7.5886	$522.67	.	$104.54
0208	Laminotomies and Laminectomies	T	51.3375	$3,535.92	.	$707.19
0209	Level II Extended EEG, Sleep, and Cardiovascular Studies	S	11.3359	$780.77	$268.73	$156.16
0213	Level I Extended EEG, Sleep, and Cardiovascular Studies	S	2.4194	$166.64	$53.58	$33.33
0215	Level I Nerve and Muscle Tests	S	0.6518	$44.89	.	$8.98
0216	Level III Nerve and Muscle Tests	S	2.7030	$186.17	.	$37.24
0218	Level II Nerve and Muscle Tests	S	1.1728	$80.78	.	$16.16
0220	Level I Nerve Procedures	T	19.1325	$1,317.77	.	$263.56
0221	Level II Nerve Procedures	T	37.2747	$2,567.33	.	$513.47
0224	Implantation of Catheter/Reservoir/Shunt	T	41.9167	$2,887.05	.	$577.41

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0227	Implantation of Drug Infusion Device	T	193.1752	$13,305.14	.	$2,661.03
0229	Transcatherter Placement of Intravascular Shunt and Stents	T	116.5174	$8,025.25	.	$1,605.05
0230	Level I Eye Tests & Treatments	S	0.6053	$41.69	.	$8.34
0231	Level III Eye Tests & Treatments	S	2.3078	$158.95	.	$31.79
0232	Level I Anterior Segment Eye Procedures	T	2.5480	$175.50	$42.27	$35.10
0233	Level III Anterior Segment Eye Procedures	T	17.9021	$1,233.03	$263.12	$246.61
0234	Level IV Anterior Segment Eye Procedures	T	24.4149	$1,681.60	$511.31	$336.32
0235	Level I Posterior Segment Eye Procedures	T	5.8452	$402.59	.	$80.52
0237	Level II Posterior Segment Eye Procedures	T	23.4306	$1,613.81	.	$322.77
0238	Level I Repair and Plastic Eye Procedures	T	3.2520	$223.98	.	$44.80
0239	Level II Repair and Plastic Eye Procedures	T	8.1226	$559.45	.	$111.89
0240	Level III Repair and Plastic Eye Procedures	T	20.0091	$1,378.15	$296.20	$275.63
0241	Level IV Repair and Plastic Eye Procedures	T	26.5964	$1,831.85	$383.45	$366.37
0242	Level V Repair and Plastic Eye Procedures	T	38.8370	$2,674.94	$597.36	$534.99
0243	Strabismus/Muscle Procedures	T	25.5895	$1,762.50	$416.98	$352.50
0244	Corneal and Amniotic Membrane Transplant	T	38.9282	$2,681.22	$803.26	$536.25
0245	Level I Cataract Procedures without IOL Insert	T	14.7683	$1,017.18	$204.88	$203.44
0246	Cataract Procedures with IOL Insert	T	24.5531	$1,691.12	$495.96	$338.23
0247	Laser Eye Procedures	T	5.6106	$386.44	$104.31	$77.29
0249	Level II Cataract Procedures without IOL Insert	T	30.8241	$2,123.04	$516.99	$424.61
0250	Level I ENT Procedures	T	1.1331	$78.04	$25.10	$15.61
0251	Level II ENT Procedures	T	3.5538	$244.77	.	$48.96
0252	Level III ENT Procedures	T	7.9194	$545.46	$109.16	$109.10
0253	Level IV ENT Procedures	T	17.3388	$1,194.23	$282.29	$238.85
0254	Level V ENT Procedures	T	25.6472	$1,766.48	.	$353.30
0255	Level II Anterior Segment Eye Procedures	T	7.5341	$518.92	$124.97	$103.79
0256	Level VI ENT Procedures	T	44.6899	$3,078.06	.	$615.62
0259	Level VII ENT Procedures	T	450.9625	$31,060.49	$8,543.66	$6,212.10
0260	Level I Plain Film Except Teeth	X	0.6539	$45.04	.	$9.01
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.1014	$75.86	.	$15.18
0262	Plain Film of Teeth	X	0.4426	$30.48	.	$6.10
0263	Level I Miscellaneous Radiology Procedures	X	3.3387	$229.96	.	$46.00
0265	Level I Diagnostic and Screening Ultrasound	S	0.9038	$62.25	$22.26	$12.45
0266	Level II Diagnostic and Screening Ultrasound	S	1.3979	$96.28	$37.23	$19.26
0267	Level III Diagnostic and Screening Ultrasound	S	2.2212	$152.99	$59.84	$30.60

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0269	Level II Echocardiogram Without Contrast	S	5.8423	$402.39	.	$80.48
0270	Level III Echocardiogram Without Contrast	S	8.1617	$562.15	$133.61	$112.43
0272	Fluoroscopy	X	1.2123	$83.50	$30.47	$16.70
0274	Myelography	S	7.2463	$499.10	.	$99.82
0275	Arthrography	S	3.9933	$275.04	$68.90	$55.01
0276	Level I Digestive Radiology	S	1.2591	$86.72	$34.43	$17.35
0277	Level II Digestive Radiology	S	2.0614	$141.98	$53.90	$28.40
0278	Diagnostic Urography	S	2.5571	$176.12	$58.44	$35.23
0279	Level II Angiography and Venography	S	29.4238	$2,026.59	.	$405.32
0280	Level III Angiography and Venography	S	47.7637	$3,289.77	.	$657.96
0282	Miscellaneous Computed Axial Tomography	S	1.6478	$113.49	$37.81	$22.70
0283	Computed Tomography with Contrast	S	4.3529	$299.81	$96.62	$59.97
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast	S	6.3444	$436.98	$146.85	$87.40
0288	Bone Density:Axial Skeleton	S	1.0238	$70.52	$0.00	$0.00
0293	Level VI Anterior Segment Eye Procedures	T	109.7404	$7,558.48	.	$1,511.70
0299	Hyperthermia and Radiation Treatment Procedures	S	5.6418	$388.58	.	$77.72
0300	Level I Radiation Therapy	S	1.4202	$97.82	.	$19.57
0301	Level II Radiation Therapy	S	2.3309	$160.54	.	$32.11
0303	Treatment Device Construction	X	2.8996	$199.71	$66.95	$39.95
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.5169	$104.48	$34.63	$20.90
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.9434	$271.61	$91.38	$54.33
0307	Myocardial Positron Emission Tomography (PET) imaging	S	16.0776	$1,107.36	.	$221.48
0308	Non-Myocardial Positron Emission Tomography (PET) imaging	S	15.1285	$1,041.99	.	$208.40
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.4552	$926.74	$325.27	$185.35
0312	Radioelement Applications	S	5.1535	$354.95	.	$70.99
0313	Brachytherapy	S	10.1646	$700.10	$264.73	$140.02
0315	Level II Implantation of Neurostimulator Generator	S	273.6914	$18,850.77	.	$3,770.16
0317	Level II Miscellaneous Radiology Procedures	X	5.9108	$407.11	.	$81.43
0318	Implantation of Cranial Neurostimulator Pulse Generator and Electrode	S	331.0938	$22,804.42	$9,121.76	$4,560.89
0319	Endovascular Revascularization of the Lower Extremity	T	201.7932	$13,898.71	$5,559.48	$2,779.75
0320	Electroconvulsive Therapy	S	5.8800	$404.99	.	$81.00
0322	Brief Individual Psychotherapy	S	1.2012	$82.73	.	$16.55

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0323	Extended Individual Psychotherapy	S	1.6414	$113.05	.	$22.61
0324	Family Psychotherapy	S	1.8703	$128.82	.	$25.77
0325	Group Psychotherapy	S	0.7967	$54.87	$11.70	$10.98
0330	Dental Procedures	S	8.1928	$564.29	.	$112.86
0332	Computed Tomography without Contrast	S	2.8145	$193.85	$74.95	$38.77
0333	Computed Tomography without Contrast followed by Contrast	S	4.8528	$334.24	$116.13	$66.85
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	S	4.9789	$342.93	$135.13	$68.59
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast	S	7.7472	$533.60	$197.64	$106.72
0340	Minor Ancillary Procedures	X	0.6712	$46.23	.	$9.25
0341	Skin Tests	X	0.0809	$5.57	$2.09	$1.12
0342	Level I Pathology	X	0.1603	$11.04	.	$2.21
0343	Level III Pathology	X	0.5296	$36.48	$10.84	$7.30
0344	Level IV Pathology	X	0.8191	$56.42	$15.56	$11.29
0345	Level I Transfusion Laboratory Procedures	X	0.2167	$14.93	.	$2.99
0346	Level II Transfusion Laboratory Procedures	X	0.3642	$25.08	.	$5.02
0347	Level III Transfusion Laboratory Procedures	X	0.7059	$48.62	.	$9.73
0350	Administration of flu and PPV vaccine	S	0.3826	$26.35	$0.00	$0.00
0360	Level I Alimentary Tests	X	1.7442	$120.13	$33.88	$24.03
0361	Level II Alimentary Tests	X	4.1013	$282.48	$83.23	$56.50
0363	Level I Otorhinolaryngologic Function Tests	X	0.9181	$63.24	$17.10	$12.65
0364	Level I Audiometry	X	0.4748	$32.70	$7.06	$6.54
0365	Level II Audiometry	X	1.2699	$87.47	$18.52	$17.50
0366	Level III Audiometry	X	1.8077	$124.51	$24.94	$24.91
0367	Level I Pulmonary Test	X	0.5892	$40.58	$13.76	$8.12
0368	Level II Pulmonary Tests	X	0.8657	$59.63	$20.93	$11.93
0369	Level III Pulmonary Tests	X	3.0144	$207.62	$42.19	$41.53
0370	Allergy Tests	X	1.3134	$90.46	.	$18.10
0373	Level I Neuropsychological Testing	X	1.3342	$91.89	.	$18.38
0375	Ancillary Outpatient Services When Patient Expires	S	92.5156	$6,372.10	.	$1,274.42
0377	Level II Cardiac Imaging	S	11.0328	$759.90	.	$151.98
0378	Level II Pulmonary Imaging	S	4.6449	$319.92	$123.46	$63.99
0381	Single Allergy Tests	X	0.4819	$33.19	.	$6.64
0382	Level II Neuropsychological Testing	X	2.6972	$185.77	.	$37.16
0383	Cardiac Computed Tomographic Imaging	S	3.7293	$256.86	.	$51.38
0384	GI Procedures with Stents	T	27.8099	$1,915.43	.	$383.09

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0385	Level I Prosthetic Urological Procedures	S	102.4439	$7,055.93	.	$1,411.19
0386	Level II Prosthetic Urological Procedures	S	168.7831	$11,625.10	.	$2,325.02
0387	Level II Hysteroscopy	T	38.4941	$2,651.32	$655.55	$530.27
0388	Discography	S	24.2795	$1,672.27	.	$334.46
0389	Level I Non-imaging Nuclear Medicine	S	1.4630	$100.77	$26.88	$20.16
0390	Level I Endocrine Imaging	S	1.9280	$132.79	$47.69	$26.56
0391	Level II Endocrine Imaging	S	3.1868	$219.49	$65.46	$43.90
0392	Level II Non-imaging Nuclear Medicine	S	2.5248	$173.90	$42.39	$34.78
0393	Hematologic Processing & Studies	S	6.0745	$418.39	.	$83.68
0394	Hepatobiliary Imaging	S	3.8494	$265.13	$90.78	$53.03
0395	GI Tract Imaging	S	3.4743	$239.30	$87.01	$47.86
0396	Bone Imaging	S	3.5527	$244.70	$94.20	$48.94
0397	Vascular Imaging	S	2.9089	$200.35	$46.29	$40.07
0398	Level I Cardiac Imaging	S	4.2306	$291.39	$93.33	$58.28
0400	Hematopoietic Imaging	S	3.7316	$257.02	$91.24	$51.41
0401	Level I Pulmonary Imaging	S	2.8578	$196.83	$71.16	$39.37
0402	Level II Nervous System Imaging	S	8.6571	$596.27	.	$119.26
0403	Level I Nervous System Imaging	S	3.4879	$240.23	$72.42	$48.05
0404	Renal and Genitourinary Studies	S	4.6672	$321.46	$82.19	$64.30
0406	Level I Tumor/Infection Imaging	S	4.2121	$290.11	$88.01	$58.03
0407	Level I Radionuclide Therapy	S	3.2539	$224.12	$78.13	$44.83
0408	Level III Tumor/Infection Imaging	S	11.9819	$825.27	.	$165.06
0409	Red Blood Cell Tests	X	0.1129	$7.78	$2.19	$1.56
0412	IMRT Treatment Delivery	S	6.3625	$438.22	.	$87.65
0413	Level II Radionuclide Therapy	S	4.7474	$326.98	.	$65.40
0414	Level II Tumor/Infection Imaging	S	6.8961	$474.98	.	$95.00
0415	Level II Endoscopy Lower Airway	T	28.6278	$1,971.77	$459.92	$394.36
0418	Insertion of Left Ventricular Pacing Elect.	T	154.3377	$10,630.16	.	$2,126.04
0422	Level II Upper GI Procedures	T	16.6785	$1,148.75	$280.07	$229.75
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	56.5664	$3,896.07	.	$779.22
0425	Level II Arthroplasty or Implantation with Prosthesis	T	124.8075	$8,596.24	.	$1,719.25
0426	Level II Strapping and Cast Application	S	2.5465	$175.39	.	$35.08
0427	Level II Tube or Catheter Changes or Repositioning	T	16.3172	$1,123.86	.	$224.78
0428	Level III Sigmoidoscopy and Anoscopy	T	24.4042	$1,680.86	.	$336.18
0429	Level V Cystourethroscopy and other Genitourinary Procedures	T	46.4709	$3,200.73	.	$640.15
0432	Health and Behavior Services	S	0.4795	$33.03	.	$6.61

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0433	Level II Pathology	X	0.2478	$17.07	$5.17	$3.42
0434	Cardiac Defect Repair	T	157.0167	$10,814.68	.	$2,162.94
0436	Level I Drug Administration	S	0.3826	$26.35	.	$5.27
0437	Level II Drug Administration	S	0.5354	$36.88	.	$7.38
0438	Level III Drug Administration	S	1.0974	$75.58	.	$15.12
0439	Level IV Drug Administration	S	1.8648	$128.44	.	$25.69
0440	Level V Drug Administration	S	2.9888	$205.86	.	$41.18
0442	Dosimetric Drug Administration	S	32.5110	$2,239.23	.	$447.85
0604	Level 1 Hospital Clinic Visits	V	0.7602	$52.36	.	$10.48
0605	Level 2 Hospital Clinic Visits	V	1.0908	$75.13	.	$15.03
0606	Level 3 Hospital Clinic Visits	V	1.4477	$99.71	.	$19.95
0607	Level 4 Hospital Clinic Visits	V	1.8654	$128.48	.	$25.70
0608	Level 5 Hospital Clinic Visits	V	2.4525	$168.92	.	$33.79
0609	Level 1 Type A Emergency Visits	V	0.7516	$51.77	$12.40	$10.36
0613	Level 2 Type A Emergency Visits	V	1.2667	$87.25	$20.97	$17.45
0614	Level 3 Type A Emergency Visits	V	2.0201	$139.14	$34.33	$27.83
0615	Level 4 Type A Emergency Visits	V	3.2316	$222.58	$48.48	$44.52
0616	Level 5 Type A Emergency Visits	V	4.7846	$329.54	$72.86	$65.91
0617	Critical Care	S	6.7477	$464.75	$104.95	$92.95
0618	Trauma Response with Critical Care	S	13.4224	$924.48	.	$184.90
0621	Level I Vascular Access Procedures	T	11.3694	$783.08	.	$156.62
0622	Level II Vascular Access Procedures	T	25.6718	$1,768.17	.	$353.64
0623	Level III Vascular Access Procedures	T	30.7762	$2,119.74	.	$423.95
0624	Phlebotomy and Minor Vascular Access Device Procedures	X	0.6328	$43.58	$12.65	$8.72
0626	Level 1 Type B Emergency Visits	V	0.6005	$41.36	.	$8.28
0627	Level 2 Type B Emergency Visits	V	0.8599	$59.23	.	$11.85
0628	Level 3 Type B Emergency Visits	V	1.4740	$101.52	.	$20.31
0629	Level 4 Type B Emergency Visits	V	2.4026	$165.48	.	$33.10
0630	Level 5 Type B Emergency Visits	V	3.9671	$273.24	.	$54.65
0648	Level IV Breast Surgery	T	63.9911	$4,407.45	.	$881.49
0651	Complex Interstitial Radiation Source Application	S	16.3985	$1,129.46	.	$225.90
0652	Insertion of Intraperitoneal and Pleural Catheters	T	31.0010	$2,135.22	.	$427.05
0653	Vascular Reconstruction/Fistula Repair with Device	T	45.1001	$3,106.31	.	$621.27
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	108.0987	$7,445.41	.	$1,489.09
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T	137.7042	$9,484.51	.	$1,896.91

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	105.6783	$7,278.70	.	$1,455.74
0659	Hyperbaric Oxygen	S	1.5244	$104.99	.	$21.00
0660	Level II Otorhinolaryngologic Function Tests	X	1.4693	$101.20	$27.10	$20.24
0661	Level V Pathology	X	2.1892	$150.78	.	$30.16
0662	CT Angiography	S	4.9151	$338.53	$114.37	$67.71
0664	Level I Proton Beam Radiation Therapy	S	14.9792	$1,031.71	.	$206.35
0665	Bone Density:AppendicularSkeleton	S	0.4662	$32.11	$0.00	$0.00
0667	Level II Proton Beam Radiation Therapy	S	19.5948	$1,349.61	.	$269.93
0668	Level I Angiography and Venography	S	10.4347	$718.70	.	$143.74
0672	Level III Posterior Segment Eye Procedures	T	40.9566	$2,820.93	.	$564.19
0673	Level V Anterior Segment Eye Procedures	T	43.2387	$2,978.11	$649.56	$595.63
0674	Prostate Cryoablation	T	116.4217	$8,018.66	.	$1,603.74
0676	Thrombolysis and Other Device Revisions	T	2.3474	$161.68	.	$32.34
0678	External Counterpulsation	T	1.4754	$101.62	.	$20.33
0679	Level II Resuscitation and Cardioversion	S	5.4006	$371.97	$95.30	$74.40
0680	Insertion of Patient Activated Event Recorders	S	78.3883	$5,399.07	.	$1,079.82
0683	Level II Photochemotherapy	S	2.9132	$200.65	.	$40.13
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.7353	$670.53	.	$134.11
0687	Revision/Removal of Neurostimulator Electrodes	T	21.7224	$1,496.15	$397.37	$299.23
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	29.0860	$2,003.33	$768.94	$400.67
0690	Level I Electronic Analysis of Devices	S	0.5093	$35.08	$8.67	$7.02
0691	Level III Electronic Analysis of Devices	S	2.4221	$166.82	.	$33.37
0692	Level II Electronic Analysis of Devices	S	1.6109	$110.95	.	$22.19
0694	Mohs Surgery	T	5.3665	$369.62	$91.69	$73.93
0697	Level I Echocardiogram Without Contrast	S	3.0827	$212.32	.	$42.47
0698	Level II Eye Tests & Treatments	S	0.9697	$66.79	.	$13.36
0699	Level IV Eye Tests & Treatments	T	16.7862	$1,156.17	.	$231.24
0701	Sr89 strontium	K		$874.94	.	$174.99
0726	Dexrazoxane HCl injection	K		$207.22	.	$41.45
0728	Filgrastim 300 mcg injection	K		$231.22	.	$46.25
0731	Sargramostim injection	K		$23.65	.	$4.73
0735	Ampho b cholesteryl sulfate	K		$11.89	.	$2.38
0736	Amphotericin b liposome inj	K		$15.53	.	$3.11
0738	Rasburicase	K		$177.57	.	$35.52
0747	Chlorothiazide sodium inj	K		$432.82	.	$86.57
0751	Mechlorethamine hcl inj	K		$153.01	.	$30.61

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0752	Dactinomycin injection	K		$586.82	.	$117.37
0759	Naltrexone, depot form	K		$2.36	.	$0.48
0800	Leuprolide acetate	K		$520.49	.	$104.10
0802	Etoposide oral	K		$28.21	.	$5.65
0807	Aldesleukin injection	K		$913.37	.	$182.68
0809	Bcg live intravesical vac	K		$113.85	.	$22.77
0810	Goserelin acetate implant	K		$192.46	.	$38.50
0812	Carmustine injection	K		$174.22	.	$34.85
0814	Asparaginase injection	K		$62.87	.	$12.58
0820	Daunorubicin injection	K		$15.35	.	$3.07
0821	Daunorubicin citrate inj	K		$57.12	.	$11.43
0823	Docetaxel injection	K		$17.84	.	$3.57
0825	Nelarabine injection	K		$108.42	.	$21.69
0827	Floxuridine injection	K		$41.33	.	$8.27
0828	Gemcitabine hcl injection	K		$146.95	.	$29.39
0830	Irinotecan injection	K		$6.07	.	$1.22
0831	Ifosfomide injection	K		$33.82	.	$6.77
0832	Idarubicin hcl injection	K		$102.98	.	$20.60
0835	Cosyntropin injection NOS	K		$69.81	.	$13.97
0836	Interferon alfa-2b inj	K		$15.91	.	$3.19
0838	Interferon gamma 1-b inj	K		$426.87	.	$85.38
0840	Inj melphalan hydrochl	K		$1,388.61	.	$277.73
0842	Fludarabine phosphate inj	K		$138.26	.	$27.66
0843	Pegaspargase injection	K		$2,460.13	.	$492.03
0844	Pentostatin injection	K		$1,217.22	.	$243.45
0849	Rituximab injection	K		$588.27	.	$117.66
0850	Streptozocin injection	K		$275.09	.	$55.02
0851	Thiotepa injection	K		$113.01	.	$22.61
0856	Porfimer sodium injection	K		$2,907.23	.	$581.45
0858	Inj cladribine	K		$24.10	.	$4.82
0861	Leuprolide acetate injeciton	K		$4.74	.	$0.95
0864	Mitoxantrone hydrochl	K		$40.45	.	$8.09
0865	Interferon alfa-n3 inj	K		$18.06	.	$3.62
0868	Oral aprepitant	K		$5.79	.	$1.16
0873	Hyalgan/supartz inj per dose	K		$89.67	.	$17.94
0874	Synvisc or synvisc-one	K		$11.83	.	$2.37
0875	Euflexxa inj per dose	K		$125.97	.	$25.20
0877	Orthovisc inj per dose	K		$173.45	.	$34.69
0878	Gallium nitrate injection	K		$2.01	.	$0.41

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0884	Rho d immune globulin inj	K		$83.54	.	$16.71
0887	Azathioprine parenteral	K		$102.84	.	$20.57
0890	Lymphocyte immune globulin	K		$492.26	.	$98.46
0900	Alglucerase injection	K		$41.58	.	$8.32
0901	Alpha 1 proteinase inhibitor	K		$3.72	.	$0.75
0902	Injection,onabotulinumtoxinA	K		$5.44	.	$1.09
0903	Cytomegalovirus imm IV /vial	K		$870.53	.	$174.11
0910	Interferon beta-1b / .25 MG	K		$182.83	.	$36.57
0913	Ganciclovir long act implant	K		$16,800.00	.	$3,360.00
0917	Adenosine injection	K		$84.21	.	$16.85
0925	Factor viii	K		$0.88	.	$0.18
0927	Factor viii recombinant	K		$1.09	.	$0.22
0928	Factor ix complex	K		$0.88	.	$0.18
0929	Anti-inhibitor	K		$1.58	.	$0.32
0931	Factor IX non-recombinant	K		$0.89	.	$0.18
0932	Factor IX recombinant	K		$1.11	.	$0.23
0933	Gamma globulin > 10 CC inj	K		$187.06	.	$37.42
0934	Capecitabine, oral	K		$22.37	.	$4.48
0935	Clonidine hydrochloride	K		$24.52	.	$4.91
0943	Octagam injection	K		$36.42	.	$7.29
0944	Gammagard liquid injection	K		$38.13	.	$7.63
0945	Rhophylac injection	K		$5.13	.	$1.03
0946	Hepagam b im injection	K		$50.43	.	$10.09
0947	Flebogamma injection	K		$35.79	.	$7.16
0948	Gamunex injection	K		$37.29	.	$7.46
0949	Frozen plasma, pooled, sd	R	0.8848	$60.94	.	$12.19
0950	Whole blood for transfusion	R	2.9448	$202.83	.	$40.57
0951	Reclast injection	K		$220.55	.	$44.11
0952	Cryoprecipitate each unit	R	0.7330	$50.49	.	$10.10
0954	RBC leukocytes reduced	R	2.8292	$194.86	.	$38.98
0955	Plasma, frz between 8-24hour	R	1.0620	$73.15	.	$14.63
0956	Plasma protein fract,5%,50ml	R	0.4019	$27.68	.	$5.54
0957	Platelets, each unit	R	1.0780	$74.25	.	$14.85
0958	Plaelet rich plasma unit	R	2.0756	$142.96	.	$28.60
0959	Red blood cells unit	R	2.2405	$154.32	.	$30.87
0960	Washed red blood cells unit	R	4.1493	$285.79	.	$57.16
0961	Albumin (human),5%, 50ml	K		$20.37	.	$4.08
0963	Albumin (human), 5%, 250 ml	K		$67.07	.	$13.42
0964	Albumin (human), 25%, 20 ml	K		$29.16	.	$5.84

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0965	Albumin (human), 25%, 50ml	K		$70.39	.	$14.08
0966	Plasmaprotein fract,5%,250ml	R	1.4345	$98.80	.	$19.76
0967	Blood split unit	R	3.0703	$211.47	.	$42.30
0968	Platelets leukoreduced irrad	R	2.0647	$142.21	.	$28.45
0969	RBC leukoreduced irradiated	R	3.5983	$247.84	.	$49.57
1009	Cryoprecipitatereducedplasma	R	1.2488	$86.01	.	$17.21
1010	Blood, l/r, cmv-neg	R	2.6086	$179.67	.	$35.94
1011	Platelets, hla-m, l/r, unit	R	11.8651	$817.22	.	$163.45
1013	Platelets leukocytes reduced	R	1.6045	$110.51	.	$22.11
1015	injection glatiramer acetate	K		$93.19	.	$18.64
1016	Blood, l/r, froz/degly/wash	R	1.6688	$114.94	.	$22.99
1017	Plt, aph/pher, l/r, cmv-neg	R	6.4027	$440.99	.	$88.20
1018	Blood, l/r, irradiated	R	2.4995	$172.16	.	$34.44
1019	Plate pheres leukoredu irrad	R	9.5146	$655.33	.	$131.07
1020	Plt, pher, l/r cmv-neg, irr	R	9.0642	$624.31	.	$124.87
1021	RBC, frz/deg/wsh, l/r, irrad	R	4.3260	$297.96	.	$59.60
1022	RBC, l/r, cmv-neg, irrad	R	4.1488	$285.75	.	$57.15
1023	Pralidoxime chloride inj	K		$89.82	.	$17.97
1052	Injection, voriconazole	K		$5.88	.	$1.18
1064	I131 iodide cap, rx	K		$17.58	.	$3.52
1083	Adalimumab injection	K		$384.61	.	$76.93
1084	Denileukin diftitox inj	K		$1,526.44	.	$305.29
1086	Temozolomide	K		$9.07	.	$1.82
1138	Hepagam b intravenous, inj	K		$50.43	.	$10.09
1139	Protein c concentrate	K		$12.43	.	$2.49
1142	Supprelin LA implant	K		$15,141.06	.	$3,028.22
1150	I131 iodide sol, rx	K		$13.26	.	$2.66
1166	Cytarabine liposome inj	K		$466.07	.	$93.22
1167	inj, epirubicin hcl	K		$1.78	.	$0.36
1168	inj, temsirolimus	K		$50.35	.	$10.07
1178	Busulfan injection	K		$16.45	.	$3.29
1203	Verteporfin injection	K		$9.49	.	$1.90
1207	Octreotide injection, depot	K		$110.99	.	$22.20
1213	Antihemophilic viii/vwf comp	K		$0.91	.	$0.19
1214	inj IVIG privigen 500 mg	K		$34.76	.	$6.96
1220	Calcitonin salmon injection	K		$51.46	.	$10.30
1221	Dimethyl sulfoxide 50%	K		$70.46	.	$14.10
1222	Pentastarch 10% solution	K		$160.29	.	$32.06
1226	Inj streptokinase /250000 IU	K		$47.57	.	$9.52

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1232	Mitomycin 5 MG inj	K		$20.57	.	$4.12
1235	Valrubicin injection	K		$954.10	.	$190.82
1236	Levoleucovorin injection	G		$1.14	.	$0.23
1237	Inj iron dextran	K		$11.88	.	$2.38
1238	Topotecan oral	G		$77.10	.	$15.27
1239	Rotavirus vacc 2 dose oral	K		$101.53	.	$20.31
1240	Apligraf skin sub	K		$33.77	.	$6.76
1241	Oasis wound matrix skin sub	K		$4.38	.	$0.88
1242	Oasis burn matrix skin sub	K		$4.38	.	$0.88
1243	Integra BMWD skin sub	K		$14.91	.	$2.99
1244	Integra DRT skin sub	K		$10.13	.	$2.03
1245	Dermagraft skin sub	K		$39.73	.	$7.95
1246	Graftjacket skin sub	K		$94.23	.	$18.85
1247	Integra matrix skin sub	K		$19.04	.	$3.81
1248	Primatrix skin sub	K		$34.71	.	$6.95
1249	Cymetra allograft	K		$350.04	.	$70.01
1250	Graftjacket express allograf	K		$350.04	.	$70.01
1251	Integra flowable wound matri	K		$948.50	.	$189.70
1252	Gammagraft skin sub	K		$7.03	.	$1.41
1253	Triamcinolone A inj PRS-free	K		$3.19	.	$0.64
1254	Adenovirus vaccine, type 4	K		$23.24	.	$4.65
1255	Rotovirus vacc 3 dose, oral	K		$73.07	.	$14.62
1256	Brompheniramine maleate inj	K		$7.50	.	$1.50
1263	Antithrombin iii injection	K		$2.51	.	$0.51
1266	Interferon alfacon-1 inj	K		$6.49	.	$1.30
1268	Xyntha inj	K		$1.05	.	$0.21
1270	Alloderm skin sub	K		$32.31	.	$6.47
1272	Acetylcysteine injection	K		$2.69	.	$0.54
1274	Edetate calcium disodium inj	K		$194.86	.	$38.98
1275	Vivaglobin, inj	K		$7.10	.	$1.42
1279	Factor VIII (porcine)	K		$1.17	.	$0.24
1280	Corticotropin injection	K		$2,418.30	.	$483.66
1281	Bevacizumab injection	K		$1.45	.	$0.29
1285	Nandrolone decanoate 50 MG	K		$9.27	.	$1.86
1287	Alloskin skin sub	K		$6.63	.	$1.33
1288	Visualization adjunct	K		$1.44	.	$0.29
1289	AbobotulinumtoxinA	K		$7.62	.	$1.53
1290	Human fibrinogen conc inj	G		$72.89	.	$14.44
1291	Rilonacept injection	K		$23.86	.	$4.78

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1295	Sm 153 lexidronam	K		$7,484.58	.	$1,496.92
1296	Degarelix injection	G		$2.52	.	$0.50
1297	Ferumoxytol, non-esrd	G		$0.77	.	$0.15
1298	Cosyntropin cortrosyn inj	K		$82.31	.	$16.47
1299	Gadofosveset trisodium inj	G		$12.82	.	$0.00
1302	Inj benztropine mesylate	K		$58.24	.	$11.65
1304	Perphenazine injeciton	K		$30.91	.	$6.19
1306	Urea injection	K		$82.18	.	$16.44
1307	Oral busulfan	K		$3.66	.	$0.74
1308	Mecasermin injection	K		$20.37	.	$4.08
1309	Paclitaxel injection	K		$7.38	.	$1.48
1311	Canakinumab injection	K		$88.62	.	$17.73
1312	Hizentra injection	K		$13.23	.	$2.65
1327	imiglucerase injection	K		$41.58	.	$8.32
1331	Olanzapine long-acting inj	K		$2.73	.	$0.55
1332	Antithrombin recombinant	K		$2.93	.	$0.59
1338	Methyl aminolevulinate, top	K		$0.72	.	$0.15
1339	Oral fludarabine phosphate	G		$80.14	.	$15.88
1340	Collagenase, clost hist inj	G		$37.51	.	$7.43
1342	Matristem micromatrix	K		$1.80	.	$0.36
1345	Theraskin	K		$21.27	.	$4.26
1346	Penicillin g procaine inj	K		$11.59	.	$2.32
1347	Oxacillin sodium injeciton	K		$2.18	.	$0.44
1348	Sincalide injection	K		$71.95	.	$14.39
1349	Anidulafungin injection	K		$1.13	.	$0.23
1350	Topotecan injection	K		$27.01	.	$5.41
1491	New Technology - Level IA ($0-$10)	S		$5.00	.	$1.00
1492	New Technology - Level IB ($10-$20)	S		$15.00	.	$3.00
1493	New Technology - Level IC ($20-$30)	S		$25.00	.	$5.00
1494	New Technology - Level ID ($30-$40)	S		$35.00	.	$7.00
1495	New Technology - Level IE ($40-$50)	S		$45.00	.	$9.00
1496	New Technology - Level IA ($0-$10)	T		$5.00	.	$1.00
1497	New Technology - Level IB($10-$20)	T		$15.00	.	$3.00
1498	New Technology - Level IC ($20-$30)	T		$25.00	.	$5.00
1499	New Technology - Level ID($30-$40)	T		$35.00	.	$7.00
1500	New Technology - Level IE ($40-$50)	T		$45.00	.	$9.00
1502	New Technology - Level II ($50 - $100)	S		$75.00	.	$15.00
1503	New Technology - Level III ($100 - $200)	S		$150.00	.	$30.00
1504	New Technology - Level IV ($200 - $300)	S		$250.00	.	$50.00

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1505	New Technology - Level V ($300 - $400)	S		$350.00	.	$70.00
1506	New Technology - Level VI ($400 - $500)	S		$450.00	.	$90.00
1507	New Technology - Level VII ($500 - $600)	S		$550.00	.	$110.00
1508	New Technology - Level VIII ($600 - $700)	S		$650.00	.	$130.00
1509	New Technology - Level IX ($700 - $800)	S		$750.00	.	$150.00
1510	New Technology - Level X ($800 - $900)	S		$850.00	.	$170.00
1511	New Technology - Level XI ($900 - $1000)	S		$950.00	.	$190.00
1512	New Technology - Level XII ($1000 - $1100)	S		$1,050.00	.	$210.00
1513	New Technology - Level XIII ($1100 - $1200)	S		$1,150.00	.	$230.00
1514	New Technology - Level XIV ($1200- $1300)	S		$1,250.00	.	$250.00
1515	New Technology - Level XV ($1300 - $1400)	S		$1,350.00	.	$270.00
1516	New Technology - Level XVI ($1400 - $1500)	S		$1,450.00	.	$290.00
1517	New Technology - Level XVII ($1500-$1600)	S		$1,550.00	.	$310.00
1518	New Technology - Level XVIII ($1600- $1700)	S		$1,650.00	.	$330.00
1519	New Technology - Level IXX ($1700-$1800)	S		$1,750.00	.	$350.00
1520	New Technology - Level XX ($1800-$1900)	S		$1,850.00	.	$370.00
1521	New Technology - Level XXI ($1900-$2000)	S		$1,950.00	.	$390.00
1522	New Technology - Level XXII ($2000-$2500)	S		$2,250.00	.	$450.00
1523	New Technology - Level XXIII ($2500- $3000)	S		$2,750.00	.	$550.00
1524	New Technology - Level XXIV ($3000- $3500)	S		$3,250.00	.	$650.00
1525	New Technology - Level XXV ($3500-$4000)	S		$3,750.00	.	$750.00
1526	New Technology - Level XXVI ($4000- $4500)	S		$4,250.00	.	$850.00
1527	New Technology - Level XXVII ($4500- $5000)	S		$4,750.00	.	$950.00
1528	New Technology - Level XXVIII ($5000- $5500)	S		$5,250.00	.	$1,050.00
1529	New Technology - Level XXIX ($5500- $6000)	S		$5,750.00	.	$1,150.00
1530	New Technology - Level XXX ($6000-$6500)	S		$6,250.00	.	$1,250.00
1531	New Technology - Level XXXI ($6500- $7000)	S		$6,750.00	.	$1,350.00
1532	New Technology - Level XXXII ($7000- $7500)	S		$7,250.00	.	$1,450.00
1533	New Technology - Level XXXIII ($7500- $8000)	S		$7,750.00	.	$1,550.00
1534	New Technology - Level XXXIV ($8000- $8500)	S		$8,250.00	.	$1,650.00
1535	New Technology - Level XXXV ($8500- $9000)	S		$8,750.00	.	$1,750.00
1536	New Technology - Level XXXVI ($9000- $9500)	S		$9,250.00	.	$1,850.00
1537	New Technology - Level XXXVII ($9500- $10000)	S		$9,750.00	.	$1,950.00
1539	New Technology - Level II ($50 - $100)	T		$75.00	.	$15.00
1540	New Technology - Level III ($100 - $200)	T		$150.00	.	$30.00
1541	New Technology - Level IV ($200 - $300)	T		$250.00	.	$50.00
1542	New Technology - Level V ($300 - $400)	T		$350.00	.	$70.00
1543	New Technology - Level VI ($400 - $500)	T		$450.00	.	$90.00
1544	New Technology - Level VII ($500 - $600)	T		$550.00	.	$110.00
1545	New Technology - Level VIII ($600 - $700)	T		$650.00	.	$130.00
1546	New Technology - Level IX ($700 - $800)	T		$750.00	.	$150.00
1547	New Technology - Level X ($800 - $900)	T		$850.00	.	$170.00
1548	New Technology - Level XI ($900 - $1000)	T		$950.00	.	$190.00
1549	New Technology - Level XII ($1000 - $1100)	T		$1,050.00	.	$210.00
1550	New Technology - Level XIII ($1100 - $1200)	T		$1,150.00	.	$230.00
1551	New Technology - Level XIV ($1200- $1300)	T		$1,250.00	.	$250.00
1552	New Technology - Level XV ($1300 - $1400)	T		$1,350.00	.	$270.00
1553	New Technology - Level XVI ($1400 - $1500)	T		$1,450.00	.	$290.00
1554	New Technology - Level XVII ($1500-$1600)	T		$1,550.00	.	$310.00
1555	New Technology - Level XVIII ($1600- $1700)	T		$1,650.00	.	$330.00
1556	New Technology - Level XIX ($1700-$1800)	T		$1,750.00	.	$350.00
1557	New Technology - Level XX ($1800-$1900)	T		$1,850.00	.	$370.00
1558	New Technology - Level XXI ($1900-$2000)	T		$1,950.00	.	$390.00
1559	New Technology - Level XXII ($2000-$2500)	T		$2,250.00	.	$450.00
1560	New Technology - Level XXIII ($2500- $3000)	T		$2,750.00	.	$550.00
1561	New Technology - Level XXIV ($3000- $3500)	T		$3,250.00	.	$650.00
1562	New Technology - Level XXV ($3500-$4000)	T		$3,750.00	.	$750.00
1563	New Technology - Level XXVI ($4000- $4500)	T		$4,250.00	.	$850.00
1564	New Technology - Level XXVII ($4500- $5000)	T		$4,750.00	.	$950.00
1565	New Technology - Level XXVIII ($5000- $5500)	T		$5,250.00	.	$1,050.00

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1566	New Technology - Level XXIX ($5500-$6000)	T		$5,750.00	.	$1,150.00
1567	New Technology - Level XXX ($6000-$6500)	T		$6,250.00	.	$1,250.00
1568	New Technology - Level XXXI ($6500-$7000)	T		$6,750.00	.	$1,350.00
1569	New Technology - Level XXXII ($7000-$7500)	T		$7,250.00	.	$1,450.00
1570	New Technology - Level XXXIII ($7500-$8000)	T		$7,750.00	.	$1,550.00
1571	New Technology - Level XXXIV ($8000-$8500)	T		$8,250.00	.	$1,650.00
1572	New Technology - Level XXXV ($8500-$9000)	T		$8,750.00	.	$1,750.00
1573	New Technology - Level XXXVI ($9000-$9500)	T		$9,250.00	.	$1,850.00
1574	New Technology - Level XXXVII ($9500-$10000)	T		$9,750.00	.	$1,950.00
1605	Abciximab injection	K		$486.03	.	$97.21
1607	Eptifibatide injection	K		$19.91	.	$3.99
1608	Etanercept injection	K		$198.44	.	$39.69
1609	Rho(D) immune globulin h, sd	K		$17.25	.	$3.45
1612	Daclizumab, parenteral	K		$521.38	.	$104.28
1613	Trastuzumab injection	K		$67.64	.	$13.53
1630	Hep b ig, im	K		$114.18	.	$22.84
1631	Baclofen intrathecal trial	K		$72.46	.	$14.50
1633	Alefacept	K		$33.05	.	$6.61
1643	Y90 ibritumomab, rx	K		$30,717.68	.	$6,143.54
1645	I131 tositumomab, rx	K		$29,697.39	.	$5,939.48
1670	Tetanus immune globulin inj	K		$230.10	.	$46.02
1675	P32 Na phosphate	K		$162.87	.	$32.58
1676	P32 chromic phosphate	K		$154.15	.	$30.83
1683	Basiliximab	K		$2,017.51	.	$403.51
1684	Corticorelin ovine triflutal	K		$4.77	.	$0.96
1685	Darbepoetin alfa, non-esrd	K		$2.87	.	$0.58
1686	Epoetin alfa, non-esrd	K		$9.59	.	$1.92
1687	Digoxin immune fab (ovine)	K		$500.91	.	$100.19
1688	Ethanolamine oleate	K		$148.55	.	$29.71
1689	Fomepizole	K		$7.49	.	$1.50
1690	Hemin	K		$8.41	.	$1.69
1693	Lepirudin	K		$277.67	.	$55.54
1694	Ziconotide injection	K		$6.54	.	$1.31

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1695	Nesiritide injection	K		$39.90	.	$7.98
1696	Palifermin injection	K		$11.25	.	$2.25
1697	Pegaptanib sodium injection	K		$1,011.14	.	$202.23
1700	Inj secretin synthetic human	K		$27.23	.	$5.45
1701	Treprostinil injection	K		$59.92	.	$11.99
1704	Humate-P, inj	K		$0.87	.	$0.18
1705	Factor viia	K		$1.36	.	$0.28
1709	Azacitidine injection	K		$5.08	.	$1.02
1710	Clofarabine injection	K		$114.32	.	$22.87
1711	Vantas implant	K		$1,470.47	.	$294.10
1712	Paclitaxel protein bound	K		$9.30	.	$1.86
1716	Brachytx, non-str, Gold-198	U	2.7603	$190.12	.	$38.03
1717	Brachytx, non-str, HDR Ir-192	U	3.1777	$218.87	.	$43.78
1719	Brachytx, NS, Non-HDRIr-192	U	0.4075	$28.07	.	$5.62
1738	Oxaliplatin	K		$4.67	.	$0.94
1739	Pegademase bovine, 25 iu	K		$245.00	.	$49.00
1740	Diazoxide injection	K		$1.04	.	$0.21
1741	Urofollitropin, 75 iu	K		$59.28	.	$11.86
1749	Endo, colon, retro imaging	H				
2210	Methyldopate hcl injection	K		$39.84	.	$7.97
2616	Brachytx, non-str,Yttrium-90	U	240.5603	$16,568.83	.	$3,313.77
2632	Iodine I-125 sodium iodide	U	0.3143	$21.65	.	$4.33
2634	Brachytx, non-str, HA, I-125	U	0.8166	$56.24	.	$11.25
2635	Brachytx, non-str, HA, P-103	U	0.4159	$28.65	.	$5.73
2636	Brachy linear, non-str,P-103	U	0.5394	$37.15	.	$7.43
2638	Brachytx, stranded, I-125	U	0.6043	$41.62	.	$8.33
2639	Brachytx, non-stranded,I-125	U	0.5307	$36.55	.	$7.31
2640	Brachytx, stranded, P-103	U	1.0560	$72.73	.	$14.55
2641	Brachytx, non-stranded,P-103	U	0.9519	$65.56	.	$13.12
2642	Brachytx, stranded, C-131	U	1.8044	$124.28	.	$24.86
2643	Brachytx, non-stranded,C-131	U	0.9665	$66.57	.	$13.32
2698	Brachytx, stranded, NOS	U	0.6043	$41.62	.	$8.33
2699	Brachytx, non-stranded, NOS	U	0.4075	$28.07	.	$5.62
2731	Immune globulin, powder	K		$29.12	.	$5.83
2770	Quinupristin/dalfopristin	K		$158.36	.	$31.68
3041	Bivalirudin	K		$2.52	.	$0.51
3043	Gamma globulin 1 CC inj	K		$18.71	.	$3.75
3050	Sermorelin acetate injection	K		$1.78	.	$0.36
7000	Amifostine	K		$315.66	.	$63.14

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
7011	Oprelvekin injection	K		$242.29	.	$48.46
7034	Somatropin injection	K		$57.51	.	$11.51
7035	Teniposide	K		$320.61	.	$64.13
7036	Urokinase 250,000 IU inj	K		$453.41	.	$90.69
7038	Monoclonal antibodies	K		$1,122.83	.	$224.57
7041	Tirofiban HCl	K		$7.96	.	$1.60
7042	Capecitabine, oral	K		$6.78	.	$1.36
7043	Infliximab injection	K		$59.96	.	$12.00
7046	Doxorubicin hcl liposome inj	K		$482.21	.	$96.45
7048	Alteplase recombinant	K		$38.34	.	$7.67
7049	Filgrastim 480 mcg injection	K		$363.35	.	$72.67
7051	Leuprolide acetate implant	K		$4,774.35	.	$954.87
7308	Aminolevulinic acid hcl top	K		$137.64	.	$27.53
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	T	156.6215	$10,787.46	.	$2,157.50
8001	LDR Prostate Brachytherapy Composite	T	46.8848	$3,229.24	.	$645.85
8002	Level I Extended Assessment & Management Composite	V	5.7236	$394.22	.	$78.85
8003	Level II Extended Assessment & Management Composite	V	10.3712	$714.33	.	$142.87
8004	Ultrasound Composite	S	2.7650	$190.44	.	$38.09
8005	CT and CTA without Contrast Composite	S	6.1103	$420.85	.	$84.17
8006	CT and CTA with Contrast Composite	S	9.1267	$628.61	.	$125.73
8007	MRI and MRA without Contrast Composite	S	10.2516	$706.09	.	$141.22
8008	MRI and MRA with Contrast Composite	S	14.4444	$994.87	.	$198.98
9001	Linezolid injection	K		$33.05	.	$6.61
9002	Tenecteplase injection	K		$47.18	.	$9.44
9003	Palivizumab	K		$74.65	.	$14.93
9004	Gemtuzumab ozogamicin inj	K		$2,660.02	.	$532.01
9005	Reteplase injection	K		$1,300.11	.	$260.03
9006	Tacrolimus injection	K		$138.17	.	$27.64
9012	Arsenic trioxide injection	K		$36.90	.	$7.38
9018	Inj, rimabotulinumtoxinB	K		$10.48	.	$2.10
9019	Caspofungin acetate	K		$11.99	.	$2.40
9022	IM inj interferon beta 1-a	K		$212.28	.	$42.46
9023	Rho d immune globulin	K		$22.45	.	$4.49
9024	Amphotericin b lipid complex	K		$9.73	.	$1.95
9032	Baclofen 10 MG injection	K		$202.00	.	$40.40
9033	Cidofovir injection	K		$754.01	.	$150.81
9038	Inj estrogen conjugate	K		$92.21	.	$18.45

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9042	Glucagon hydrochloride	K		$85.12	.	$17.03
9044	Ibutilide fumarate injection	K		$188.42	.	$37.69
9046	Iron sucrose injection	K		$0.36	.	$0.08
9104	Antithymocyte globuln rabbit	K		$413.57	.	$82.72
9108	Thyrotropin injection	K		$1,043.12	.	$208.63
9110	Alemtuzumab injection	K		$567.94	.	$113.59
9115	Zoledronic acid	K		$220.99	.	$44.20
9119	Injection, pegfilgrastim 6mg	K		$2,441.95	.	$488.39
9120	Injection, Fulvestrant	K		$82.23	.	$16.45
9121	Injection, argatroban	K		$19.03	.	$3.81
9122	Triptorelin pamoate	K		$180.22	.	$36.05
9124	Daptomycin injection	K		$0.45	.	$0.09
9125	Risperidone, long acting	K		$5.00	.	$1.00
9126	Natalizumab injection	K		$8.68	.	$1.74
9133	Rabies ig, im/sc	K		$165.12	.	$33.03
9134	Rabies ig, heat treated	K		$159.71	.	$31.95
9135	Varicella-zoster ig, im	K		$129.48	.	$25.90
9137	Bcg vaccine, percut	K		$110.93	.	$22.19
9139	Rabies vaccine, im	K		$200.66	.	$40.14
9140	Rabies vaccine, id	K		$107.83	.	$21.57
9143	Meningococcal vaccine, sc	K		$102.44	.	$20.49
9144	Encephalitis vaccine, sc	K		$101.12	.	$20.23
9145	Meningococcal vaccine, im	K		$95.06	.	$19.02
9207	Bortezomib injection	K		$38.92	.	$7.79
9208	Agalsidase beta injection	K		$134.90	.	$26.98
9209	Laronidase injection	K		$25.31	.	$5.07
9210	Palonosetron hcl	K		$18.23	.	$3.65
9213	Pemetrexed injection	K		$50.96	.	$10.20
9214	Bevacizumab injection	K		$57.89	.	$11.58
9215	Cetuximab injection	K		$49.27	.	$9.86
9217	Leuprolide acetate suspnsion	K		$206.25	.	$41.25
9224	Galsulfase injection	K		$333.68	.	$66.74
9225	Fluocinolone acetonide implt	K		$19,162.50	.	$3,832.50
9227	Micafungin sodium injection	K		$1.06	.	$0.22
9228	Tigecycline injection	K		$1.23	.	$0.25
9229	Ibandronate sodium injection	K		$142.82	.	$28.57
9230	Abatacept injection	K		$19.99	.	$4.00
9231	Decitabine injection	K		$30.45	.	$6.09
9232	Idursulfase injection	K		$450.74	.	$90.15

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9233	Ranibizumab injection	K		$401.39	.	$80.28
9234	Alglucosidase alfa injection	K		$133.92	.	$26.79
9235	Panitumumab injection	K		$86.56	.	$17.32
9236	Eculizumab injection	K		$183.75	.	$36.75
9237	Inj, lanreotide acetate	K		$29.75	.	$5.95
9240	injection, ixabepilone	K		$63.14	.	$12.63
9242	Injection, fosaprepitant	K		$1.67	.	$0.34
9243	Bendamustine injection	K		$18.33	.	$3.67
9244	Regadenoson injection	K		$50.80	.	$10.16
9245	Romiplostim injection	K		$44.71	.	$8.95
9247	Inj, iobenguane, I-123, dx	G		$2,394.59	.	$0.00
9248	Inj, clevidipine butyrate	K		$2.97	.	$0.60
9249	Certolizumab pegol inj	G		$3.96	.	$0.78
9250	Artiss fibrin sealant	G		$122.05	.	$24.18
9251	C1 esterase inhibitor inj	G		$42.75	.	$8.47
9252	Plerixafor injection	G		$281.67	.	$55.80
9253	Temozolomide injection	G		$4.90	.	$0.97
9254	Injection, lacosamide	K		$0.16	.	$0.04
9255	Paliperidone palmitate inj	G		$6.52	.	$1.29
9256	Dexamethasone intra implant	G		$196.10	.	$38.85
9258	Telavancin injection	G		$1.87	.	$0.37
9259	Pralatrexate injection	G		$165.63	.	$32.81
9260	Ofatumumab injection	G		$45.47	.	$9.01
9261	Ustekinumab injection	G		$107.11	.	$21.22
9263	Ecallantide injection	G		$275.28	.	$54.54
9264	Tocilizumab injection	G		$3.48	.	$0.69
9265	Romidepsin injection	G		$219.30	.	$43.45
9267	Wilate injection	G		$71.19	.	$14.10
9268	Capsaicin 8% patch	G		$25.55	.	$5.06
9269	C-1 esterase, berinert	G		$27.53	.	$5.45
9270	Gammaplex IVIG	G		$60.42	.	$11.97
9271	Velaglucerase alfa	G		$350.60	.	$69.46
9272	Inj, denosumab	G		$14.58	.	$2.89
9273	Sipuleucel-T, per infusion	G		$32,860.00	.	$6,510.00
9274	Crotalidae Poly Immune Fab	G		$1,947.49	.	$385.82
9275	Hexaminolevulinate HCl	G		$636.00	.	$0.00
9276	Cabazitaxel injection	G		$141.33	.	$28.00
9277	Lumizyme, 1 mg	G		$14.84	.	$2.94
9278	Incobotulinumtoxin A	G		$5.57	.	$1.10

ADDENDUM A.—OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9279	Injection, ibuprofen	G		$1.40		$0.28
9300	Omalizumab injection	K		$20.19	.	$4.04
9358	SurgiMend, fetal	K		$10.60	.	$2.12
9360	SurgiMend, neonatal	G		$11.26	.	$2.23
9361	NeuroMend nerve wrap	G		$251.08		$0.00
9362	Implnt,bon void filler-strip	G		$50.09	.	$9.92
9363	Integra Meshed Bil Wound Mat	G		$19.56	.	$3.88
9364	Porcine implant, Permacol	G		$18.85		$0.00
9367	Endoform Dermal Template	G		$4.35	.	$0.86
9500	Platelets, irradiated	R	2.1010	$144.71	.	$28.95
9501	Platelet pheres leukoreduced	R	7.8186	$538.51	.	$107.71
9502	Platelet pheresis irradiated	R	6.5749	$452.85	.	$90.57
9503	Fr frz plasma donor retested	R	1.0328	$71.14	.	$14.23
9504	RBC deglycerolized	R	5.2989	$364.97	.	$73.00
9505	RBC irradiated	R	3.2550	$224.19	.	$44.84
9506	Granulocytes, pheresis unit	R	21.8976	$1,508.22	.	$301.65
9507	Platelets, pheresis	R	6.6574	$458.54	.	$91.71
9508	Plasma 1 donor frz w/in 8 hr	R	1.1521	$79.35	.	$15.87

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
0016T	Thermotx choroid vasc lesion	N	CH	D5		
0017T	Photocoagulat macular drusen	N	CH	D5		
0099T*	Implant corneal ring	Y		R2	16.538	$693.59
0100T	Prosth retina receive&gen	Y		G2	37.8357	$1,586.79
0101T	Extracorp shockwv tx hi enrg	Y		G2	29.7869	$1,249.23
0102T	Extracorp shockwv tx anesth	Y		G2	29.7869	$1,249.23
0123T	Scleral fistulization	Y		G2	22.5545	$945.91
0124T*	Conjunctival drug placement	Y		R2	2.3538	$98.72

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(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
0176T	Aqu canal dilat w/o retent	N	CH	D5		
0177T	Aqu canal dilat w retent	N	CH	D5		
0186T	Suprachoroidal drug delivery	Y		G2	21.6452	$907.78
0190T	Place intraoc radiation src	Y		G2	21.6452	$907.78
0191T	Insert ant segment drain int	Y		G2	39.9439	$1,675.21
0192T	Insert ant segment drain ext	Y		G2	39.9439	$1,675.21
0193T	Rf bladder neck microremodel	N	CH	D5		
0200T	Perq sacral augmt unilat inj	Y		G2	21.2238	$890.10
0201T	Perq sacral augmt bilat inj	Y		G2	29.7869	$1,249.23
0213T	Njx paravert w/us cer/thor	Y		G2	7.0103	$294.00
0214T	Njx paravert w/us cer/thor	Y		G2	2.465	$103.38
0215T	Njx paravert w/us cer/thor	Y		G2	2.465	$103.38
0216T	Njx paravert w/us lumb/sac	Y		G2	7.0103	$294.00
0217T	Njx paravert w/us lumb/sac	Y		G2	2.465	$103.38
0218T	Njx paravert w/us lumb/sac	Y		G2	2.465	$103.38
0226T*	Anoscopy hra w/spec collect	N		R2	0.6201	$26.01
0227T*	Anoscopy hra w/biopsy	Y		R2	5.3564	$224.64
0228T	Njx tfrml eprl w/us cer/thor	Y		G2	7.0103	$294.00
0229T	Njx tfrml eprl w/us cer/thor	Y		G2	3.5865	$150.41
0230T	Njx tfrml eprl w/us lumb/sac	Y		G2	7.0103	$294.00
0231T	Njx tfrml eprl w/us lumb/sac	Y		G2	3.5865	$150.41
0232T*	Njx platelet plasma	N		R2	0.6201	$26.01
0238T	Trluml perip athrc iliac art	Y	NI	G2	85.6595	$3,592.47
0249T	Ligation hemorrhoid w/us	Y	NI	G2	14.8848	$624.25
0250T	Insert bronchial valve	Y	NI	G2	26.4464	$1,109.14
0251T	Remov bronchial valve addl	Y	NI	G2	9.7005	$406.83
0252T	Bronchscpc rmvl bronch valve	Y	NI	G2	9.7005	$406.83
0253T	Insert aqueous drain device	Y	NI	G2	22.5545	$945.91
0260T	Hypthrm bdy neonate 28d/<	N	NI	N1		
0261T	Hypthrm head neonate 28d/<	N	NI	N1		
10021	Fna w/o image	Y		P2	1.4506	$60.84
10022	Fna w/image	Y		G2	4.235	$177.61
10040	Acne surgery	Y		P2	0.8409	$35.27
10060	Drainage of skin abscess	Y		P3		$47.73
10061	Drainage of skin abscess	Y		P2	1.377	$57.75

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
10080	Drainage of pilonidal cyst	Y		P2	1.377	$57.75
10081	Drainage of pilonidal cyst	Y		P3		$118.42
10120	Remove foreign body	Y		P3		$65.08
10121	Remove foreign body	Y		A2	16.7008	$700.41
10140	Drainage of hematoma/fluid	Y		P3		$70.44
10160	Puncture drainage of lesion	Y		P2	1.377	$57.75
10180	Complex drainage wound	Y		A2	18.6604	$782.60
11000	Debride infected skin	Y		P3		$22.46
11001	Debride infected skin add-on	Y		P3		$7.40
11010	Debride skin at fx site	Y		A2	4.7009	$197.15
11011	Debride skin musc at fx site	Y		A2	4.7009	$197.15
11012	Deb skin bone at fx site	Y		A2	4.7009	$197.15
11040	Debride skin, partial	N	CH	D5		
11041	Debride skin, full	N	CH	D5		
11042	Deb subq tissue 20 sq cm/<	Y		A2	2.5236	$105.84
11043	Deb musc/fascia 20 sq cm/<	Y		A2	2.5236	$105.84
11044	Deb bone 20 sq cm/<	Y		A2	7.8457	$329.04
11045	Deb subq tissue add-on	Y	NI	G2	2.5236	$105.84
11046	Deb musc/fascia add-on	Y	NI	G2	2.5236	$105.84
11047	Deb bone add-on	Y	NI	G2	7.8457	$329.04
11055	Trim skin lesion	Y		P3		$24.25
11056	Trim skin lesions 2 to 4	Y		P3		$26.54
11057	Trim skin lesions over 4	Y		P3		$29.86
11100	Biopsy skin lesion	Y		P3		$53.60
11101	Biopsy skin add-on	Y		P3		$12.76
11200	Removal of skin tags	Y		P2	0.8409	$35.27
11201	Remove skin tags add-on	Y		P3		$5.61
11300	Shave skin lesion	Y		P2	0.8409	$35.27
11301	Shave skin lesion	Y		P2	0.8409	$35.27
11302	Shave skin lesion	Y		P2	0.8409	$35.27
11303	Shave skin lesion	Y		P2	1.3834	$58.02
11305	Shave skin lesion	Y		P3		$32.41
11306	Shave skin lesion	Y		P2	0.8409	$35.27
11307	Shave skin lesion	Y		P2	0.8409	$35.27
11308	Shave skin lesion	Y		P2	0.8409	$35.27
11310	Shave skin lesion	Y		P2	0.8409	$35.27

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(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
11311	Shave skin lesion	Y		P2	0.8409	$35.27
11312	Shave skin lesion	Y		P2	0.8409	$35.27
11313	Shave skin lesion	Y		P2	0.8409	$35.27
11400	Exc tr-ext b9+marg 0.5 < cm	Y		P3		$62.02
11401	Exc tr-ext b9+marg 0.6-1 cm	Y		P3		$69.93
11402	Exc tr-ext b9+marg 1.1-2 cm	Y		P3		$76.82
11403	Exc tr-ext b9+marg 2.1-3 cm	Y		P3		$83.20
11404	Exc tr-ext b9+marg 3.1-4 cm	Y		A2	16.7008	$700.41
11406	Exc tr-ext b9+marg > 4.0 cm	Y		A2	16.7008	$700.41
11420	Exc h-f-nk-sp b9+marg 0.5 <	Y		P3		$58.70
11421	Exc h-f-nk-sp b9+marg 0.6-1	Y		P3		$70.95
11422	Exc h-f-nk-sp b9+marg 1.1-2	Y		P3		$77.59
11423	Exc h-f-nk-sp b9+marg 2.1-3	Y		P3		$86.26
11424	Exc h-f-nk-sp b9+marg 3.1-4	Y		A2	16.7008	$700.41
11426	Exc h-f-nk-sp b9+marg > 4 cm	Y		A2	22.0775	$925.91
11440	Exc face-mm b9+marg 0.5 < cm	Y		P3		$66.10
11441	Exc face-mm b9+marg 0.6-1 cm	Y		P3		$77.08
11442	Exc face-mm b9+marg 1.1-2 cm	Y		P3		$84.99
11443	Exc face-mm b9+marg 2.1-3 cm	Y		P3		$94.69
11444	Exc face-mm b9+marg 3.1-4 cm	Y		A2	7.8457	$329.04
11446	Exc face-mm b9+marg > 4 cm	Y		A2	22.0775	$925.91
11450	Removal sweat gland lesion	Y		A2	22.0775	$925.91
11451	Removal sweat gland lesion	Y		A2	22.0775	$925.91
11462	Removal sweat gland lesion	Y		A2	22.0775	$925.91
11463	Removal sweat gland lesion	Y		A2	22.0775	$925.91
11470	Removal sweat gland lesion	Y		A2	22.0775	$925.91
11471	Removal sweat gland lesion	Y		A2	22.0775	$925.91
11600	Exc tr-ext mlg+marg 0.5 < cm	Y		P3		$89.07
11601	Exc tr-ext mlg+marg 0.6-1 cm	Y		P3		$106.17
11602	Exc tr-ext mlg+marg 1.1-2 cm	Y		P3		$115.87
11603	Exc tr-ext mlg+marg 2.1-3 cm	Y		P3		$124.55

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(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
11604	Exc tr-ext mlg+marg 3.1-4 cm	Y		A2	7.8457	$329.04
11606	Exc tr-ext mlg+marg > 4 cm	Y		A2	16.7008	$700.41
11620	Exc h-f-nk-sp mlg+marg 0.5 <	Y		P3		$91.37
11621	Exc h-f-nk-sp mlg+marg 0.6-1	Y		P3		$107.19
11622	Exc h-f-nk-sp mlg+marg 1.1-2	Y		P3		$118.42
11623	Exc h-f-nk-sp mlg+marg 2.1-3	Y		P3		$129.40
11624	Exc h-f-nk-sp mlg+marg 3.1-4	Y		A2	16.7008	$700.41
11626	Exc h-f-nk-sp mlg+mar > 4 cm	Y		A2	22.0775	$925.91
11640	Exc face-mm malig+marg 0.5 <	Y		P3		$95.96
11641	Exc face-mm malig+marg 0.6-1	Y		P3		$111.79
11642	Exc face-mm malig+marg 1.1-2	Y		P3		$124.55
11643	Exc face-mm malig+marg 2.1-3	Y		P3		$136.03
11644	Exc face-mm malig+marg 3.1-4	Y		A2	16.7008	$700.41
11646	Exc face-mm mlg+marg > 4 cm	Y		A2	22.0775	$925.91
11719	Trim nail(s)	Y		P3		$11.48
11720	Debride nail 1-5	Y		P3		$14.04
11721	Debride nail 6 or more	Y		P3		$16.59
11730	Removal of nail plate	Y		P2	0.8409	$35.27
11732	Remove nail plate add-on	Y		P3		$16.59
11740	Drain blood from under nail	Y		P2	0.3996	$16.76
11750	Removal of nail bed	Y		P3		$90.35
11752	Remove nail bed/finger tip	Y		P3		$127.86
11755	Biopsy nail unit	Y		P3		$61.25
11760	Repair of nail bed	Y		G2	1.2314	$51.64
11762	Reconstruction of nail bed	Y		P3		$116.63
11765	Excision of nail fold toe	Y		P2	0.8409	$35.27
11770	Removal of pilonidal lesion	Y		A2	22.0775	$925.91
11771	Removal of pilonidal lesion	Y		A2	22.0775	$925.91
11772	Removal of pilonidal lesion	Y		A2	22.0775	$925.91
11900	Injection into skin lesions	Y		P3		$26.54
11901	Added skin lesions injection	Y		P3		$29.86

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
11920	Correct skin color defects	Y		P3		$82.18
11921	Correct skin color defects	Y		P3		$92.39
11922	Correct skin color defects	Y		P3		$30.63
11950	Therapy for contour defects	Y		P3		$28.84
11951	Therapy for contour defects	Y		P3		$38.28
11952	Therapy for contour defects	Y		P3		$47.22
11954	Therapy for contour defects	Y		P2	1.2314	$51.64
11960	Insert tissue expander(s)	Y		A2	20.5842	$863.28
11970	Replace tissue expander	Y		A2	43.7154	$1,833.38
11971	Remove tissue expander(s)	Y		A2	22.0775	$925.91
11976	Removal of contraceptive cap	Y		P3		$55.38
11980	Implant hormone pellet(s)	N		P2	0.6201	$26.01
11981	Insert drug implant device	N		P2	0.6201	$26.01
11982	Remove drug implant device	N		P2	0.6201	$26.01
11983	Remove/insert drug implant	N		P2	0.6201	$26.01
12001	Repair superficial wound(s)	Y		P3		$46.96
12002	Repair superficial wound(s)	Y		P3		$50.53
12004	Repair superficial wound(s)	Y		P2	1.2314	$51.64
12005	Repair superficial wound(s)	Y		A2	1.2314	$51.64
12006	Repair superficial wound(s)	Y		A2	1.2314	$51.64
12007	Repair superficial wound(s)	Y		A2	1.2314	$51.64
12011	Repair superficial wound(s)	Y		P2	1.2314	$51.64
12013	Repair superficial wound(s)	Y		P2	1.2314	$51.64
12014	Repair superficial wound(s)	Y		P2	1.2314	$51.64
12015	Repair superficial wound(s)	Y		G2	1.2314	$51.64
12016	Repair superficial wound(s)	Y		A2	1.2314	$51.64
12017	Repair superficial wound(s)	Y		A2	1.2314	$51.64
12018	Repair superficial wound(s)	Y		A2	1.2314	$51.64
12020	Closure of split wound	Y		A2	4.2885	$179.86
12021	Closure of split wound	Y		A2	2.9209	$122.50
12031	Intmd wnd repair s/tr/ext	Y		P2	1.2314	$51.64
12032	Intmd wnd repair s/tr/ext	Y		P2	2.9209	$122.50
12034	Intmd wnd repair s/tr/ext	Y		A2	1.2314	$51.64
12035	Intmd wnd repair s/tr/ext	Y		A2	1.2314	$51.64
12036	Intmd wnd repair s/tr/ext	Y		A2	2.9209	$122.50
12037	Intmd wnd repair s/tr/ext	Y		A2	2.9209	$122.50

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
12041	Intmd wnd repair n-hf/genit	Y		P2	1.2314	$51.64
12042	Intmd wnd repair n-hg/genit	Y		P2	1.2314	$51.64
12044	Intmd wnd repair n-hg/genit	Y		A2	1.2314	$51.64
12045	Intmd wnd repair n-hg/genit	Y		A2	2.9209	$122.50
12046	Intmd wnd repair n-hg/genit	Y		A2	2.9209	$122.50
12047	Intmd wnd repair n-hg/genit	Y		A2	2.9209	$122.50
12051	Intmd wnd repair face/mm	Y		P2	2.9209	$122.50
12052	Intmd wnd repair face/mm	Y		P2	1.2314	$51.64
12053	Intmd wnd repair face/mm	Y		P2	1.2314	$51.64
12054	Intmd wnd repair face/mm	Y		A2	1.2314	$51.64
12055	Intmd wnd repair face/mm	Y		A2	2.9209	$122.50
12056	Intmd wnd repair face/mm	Y		A2	2.9209	$122.50
12057	Intmd wnd repair face/mm	Y		A2	2.9209	$122.50
13100	Repair of wound or lesion	Y		A2	4.2885	$179.86
13101	Repair of wound or lesion	Y		A2	4.2885	$179.86
13102	Repair wound/lesion add-on	Y		A2	4.2885	$179.86
13120	Repair of wound or lesion	Y		A2	2.9209	$122.50
13121	Repair of wound or lesion	Y		A2	2.9209	$122.50
13122	Repair wound/lesion add-on	Y		A2	1.2314	$51.64
13131	Repair of wound or lesion	Y		A2	2.9209	$122.50
13132	Repair of wound or lesion	Y		A2	4.2885	$179.86
13133	Repair wound/lesion add-on	Y		A2	2.9209	$122.50
13150	Repair of wound or lesion	Y		A2	4.2885	$179.86
13151	Repair of wound or lesion	Y		A2	4.2885	$179.86
13152	Repair of wound or lesion	Y		A2	4.2885	$179.86
13153	Repair wound/lesion add-on	Y		A2	2.9209	$122.50
13160	Late closure of wound	Y		A2	20.5842	$863.28
14000	Skin tissue rearrangement	Y		A2	15.9002	$666.84
14001	Skin tissue rearrangement	Y		A2	15.9002	$666.84
14020	Skin tissue rearrangement	Y		A2	15.9002	$666.84
14021	Skin tissue rearrangement	Y		A2	15.9002	$666.84
14040	Skin tissue rearrangement	Y		A2	15.9002	$666.84
14041	Skin tissue rearrangement	Y		A2	15.9002	$666.84
14060	Skin tissue rearrangement	Y		A2	15.9002	$666.84
14061	Skin tissue rearrangement	Y		A2	15.9002	$666.84
14301	Skin tissue rearrangement	Y		G2	20.5842	$863.28

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
14302	Skin tissue rearrange add-on	Y		G2	20.5842	$863.28
14350	Skin tissue rearrangement	Y		A2	20.5842	$863.28
15002	Wound prep trk/arm/leg	Y		A2	4.2885	$179.86
15003	Wound prep addl 100 cm	Y		A2	4.2885	$179.86
15004	Wound prep f/n/hf/g	Y		A2	4.2885	$179.86
15005	Wnd prep f/n/hf/g addl cm	Y		A2	4.2885	$179.86
15040	Harvest cultured skin graft	Y		A2	2.9209	$122.50
15050	Skin pinch graft	Y		A2	4.2885	$179.86
15100	Skin splt grft trnk/arm/leg	Y		A2	20.5842	$863.28
15101	Skin splt grft t/a/l add-on	Y		A2	20.5842	$863.28
15110	Epidrm autogrft trnk/arm/leg	Y		A2	4.2885	$179.86
15111	Epidrm autogrft t/a/l add-on	Y		A2	4.2885	$179.86
15115	Epidrm a-grft face/nck/hf/g	Y		A2	4.2885	$179.86
15116	Epidrm a-grft f/n/hf/g addl	Y		A2	4.2885	$179.86
15120	Skn splt a-grft fac/nck/hf/g	Y		A2	20.5842	$863.28
15121	Skn splt a-grft f/n/hf/g add	Y		A2	20.5842	$863.28
15130	Derm autograft trnk/arm/leg	Y		A2	15.9002	$666.84
15131	Derm autograft t/a/l add-on	Y		A2	15.9002	$666.84
15135	Derm autograft face/nck/hf/g	Y		A2	15.9002	$666.84
15136	Derm autograft f/n/hf/g add	Y		A2	15.9002	$666.84
15150	Cult epiderm grft t/arm/leg	Y		A2	4.2885	$179.86
15151	Cult epiderm grft t/a/l addl	Y		A2	4.2885	$179.86
15152	Cult epiderm graft t/a/l +%	Y		A2	4.2885	$179.86
15155	Cult epiderm graft f/n/hf/g	Y		A2	4.2885	$179.86
15156	Cult epidrm grft f/n/hfg add	Y		A2	4.2885	$179.86
15157	Cult epiderm grft f/n/hfg +%	Y		A2	4.2885	$179.86
15170	Acell graft trunk/arms/legs	Y		G2	4.2885	$179.86
15171	Acell graft t/arm/leg add-on	Y		G2	2.9209	$122.50
15175	Acellular graft f/n/hf/g	Y		G2	4.2885	$179.86
15176	Acell graft f/n/hf/g add-on	Y		G2	4.2885	$179.86
15200	Skin full graft trunk	Y		A2	15.9002	$666.84
15201	Skin full graft trunk add-on	Y		A2	15.9002	$666.84
15220	Skin full graft sclp/arm/leg	Y		A2	15.9002	$666.84
15221	Skin full graft add-on	Y		A2	4.2885	$179.86
15240	Skin full grft face/genit/hf	Y		A2	15.9002	$666.84
15241	Skin full graft add-on	Y		A2	4.2885	$179.86

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15260	Skin full graft een & lips	Y		A2	15.9002	$666.84
15261	Skin full graft add-on	Y		A2	15.9002	$666.84
15300	Apply skinallogrft t/arm/lg	Y		A2	4.2885	$179.86
15301	Apply sknallogrft t/a/l addl	Y		A2	4.2885	$179.86
15320	Apply skin allogrft f/n/hf/g	Y		A2	4.2885	$179.86
15321	Aply sknallogrft f/n/hfg add	Y		A2	4.2885	$179.86
15330	Aply acell alogrft t/arm/leg	Y		A2	4.2885	$179.86
15331	Aply acell grft t/a/l add-on	Y		A2	4.2885	$179.86
15335	Apply acell graft f/n/hf/g	Y		A2	4.2885	$179.86
15336	Aply acell grft f/n/hf/g add	Y		A2	4.2885	$179.86
15340	Apply cult skin substitute	Y		G2	2.9209	$122.50
15341	Apply cult skin sub add-on	Y		G2	2.9209	$122.50
15360	Apply cult derm sub t/a/l	Y		G2	2.9209	$122.50
15361	Aply cult derm sub t/a/l add	Y		G2	2.9209	$122.50
15365	Apply cult derm sub f/n/hf/g	Y		G2	2.9209	$122.50
15366	Apply cult derm f/hf/g add	Y		G2	2.9209	$122.50
15400	Apply skin xenograft t/a/l	Y		A2	4.2885	$179.86
15401	Apply skn xenogrft t/a/l add	Y		A2	4.2885	$179.86
15420	Apply skin xgraft f/n/hf/g	Y		A2	4.2885	$179.86
15421	Apply skn xgrft f/n/hf/g add	Y		A2	4.2885	$179.86
15430	Apply acellular xenograft	Y		A2	4.2885	$179.86
15431	Apply acellular xgraft add	Y		A2	4.2885	$179.86
15570	Form skin pedicle flap	Y		A2	20.5842	$863.28
15572	Form skin pedicle flap	Y		A2	20.5842	$863.28
15574	Form skin pedicle flap	Y		A2	20.5842	$863.28
15576	Form skin pedicle flap	Y		A2	20.5842	$863.28
15600	Skin graft	Y		A2	20.5842	$863.28
15610	Skin graft	Y		A2	20.5842	$863.28
15620	Skin graft	Y		A2	20.5842	$863.28
15630	Skin graft	Y		A2	20.5842	$863.28
15650	Transfer skin pedicle flap	Y		A2	20.5842	$863.28
15731	Forehead flap w/vasc pedicle	Y		A2	20.5842	$863.28
15732	Muscle-skin graft head/neck	Y		A2	20.5842	$863.28
15734	Muscle-skin graft trunk	Y		A2	20.5842	$863.28
15736	Muscle-skin graft arm	Y		A2	20.5842	$863.28
15738	Muscle-skin graft leg	Y		A2	20.5842	$863.28

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15740	Island pedicle flap graft	Y		A2	15.9002	$666.84
15750	Neurovascular pedicle graft	Y		A2	20.5842	$863.28
15760	Composite skin graft	Y		A2	20.5842	$863.28
15770	Derma-fat-fascia graft	Y		A2	20.5842	$863.28
15775	Hair transplant punch grafts	Y		A2	1.2314	$51.64
15776	Hair transplant punch grafts	Y		A2	1.2314	$51.64
15780	Abrasion treatment of skin	Y		P3		$360.11
15781	Abrasion treatment of skin	Y		P2	4.7009	$197.15
15782	Abrasion treatment of skin	Y		P2	4.7009	$197.15
15783	Abrasion treatment of skin	Y		P2	2.5236	$105.84
15786	Abrasion lesion single	Y		P2	0.8409	$35.27
15787	Abrasion lesions add-on	Y		P3		$26.03
15788	Chemical peel face epiderm	Y		P2	0.8409	$35.27
15789	Chemical peel face dermal	Y		P2	1.3834	$58.02
15792	Chemical peel nonfacial	Y		P2	1.3834	$58.02
15793	Chemical peel nonfacial	Y		P2	0.8409	$35.27
15819	Plastic surgery neck	Y		G2	2.9209	$122.50
15820	Revision of lower eyelid	Y		A2	20.5842	$863.28
15821	Revision of lower eyelid	Y		A2	20.5842	$863.28
15822	Revision of upper eyelid	Y		A2	20.5842	$863.28
15823	Revision of upper eyelid	Y		A2	20.5842	$863.28
15824	Removal of forehead wrinkles	Y		A2	20.5842	$863.28
15825	Removal of neck wrinkles	Y		A2	20.5842	$863.28
15826	Removal of brow wrinkles	Y		A2	20.5842	$863.28
15828	Removal of face wrinkles	Y		A2	20.5842	$863.28
15829	Removal of skin wrinkles	Y		A2	20.5842	$863.28
15830	Exc skin abd	Y		A2	22.0775	$925.91
15832	Excise excessive skin tissue	Y		A2	22.0775	$925.91
15833	Excise excessive skin tissue	Y		A2	22.0775	$925.91
15834	Excise excessive skin tissue	Y		A2	22.0775	$925.91
15835	Excise excessive skin tissue	Y		A2	22.0775	$925.91
15836	Excise excessive skin tissue	Y		A2	16.7008	$700.41
15837	Excise excessive skin tissue	Y		G2	16.7008	$700.41
15838	Excise excessive skin tissue	Y		G2	16.7008	$700.41
15839	Excise excessive skin tissue	Y		A2	16.7008	$700.41
15840	Graft for face nerve palsy	Y		A2	20.5842	$863.28

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15841	Graft for face nerve palsy	Y		A2	20.5842	$863.28
15842	Flap for face nerve palsy	Y		G2	20.5842	$863.28
15845	Skin and muscle repair face	Y		A2	20.5842	$863.28
15847	Exc skin abd add-on	Y		A2	22.0775	$925.91
15850	Removal of sutures	Y		G2	2.5236	$105.84
15851	Removal of sutures	Y		P3		$45.43
15852	Dressing change not for burn	N		R2	0.6201	$26.01
15860	Test for blood flow in graft	N		G2	0.6201	$26.01
15876	Suction assisted lipectomy	Y		A2	20.5842	$863.28
15877	Suction assisted lipectomy	Y		A2	20.5842	$863.28
15878	Suction assisted lipectomy	Y		A2	20.5842	$863.28
15879	Suction assisted lipectomy	Y		A2	20.5842	$863.28
15920	Removal of tail bone ulcer	Y		A2	4.7009	$197.15
15922	Removal of tail bone ulcer	Y		A2	20.5842	$863.28
15931	Remove sacrum pressure sore	Y		A2	22.0775	$925.91
15933	Remove sacrum pressure sore	Y		A2	22.0775	$925.91
15934	Remove sacrum pressure sore	Y		A2	20.5842	$863.28
15935	Remove sacrum pressure sore	Y		A2	20.5842	$863.28
15936	Remove sacrum pressure sore	Y		A2	15.9002	$666.84
15937	Remove sacrum pressure sore	Y		A2	20.5842	$863.28
15940	Remove hip pressure sore	Y		A2	22.0775	$925.91
15941	Remove hip pressure sore	Y		A2	22.0775	$925.91
15944	Remove hip pressure sore	Y		A2	20.5842	$863.28
15945	Remove hip pressure sore	Y		A2	20.5842	$863.28
15946	Remove hip pressure sore	Y		A2	20.5842	$863.28
15950	Remove thigh pressure sore	Y		A2	22.0775	$925.91
15951	Remove thigh pressure sore	Y		A2	22.0775	$925.91
15952	Remove thigh pressure sore	Y		A2	15.9002	$666.84
15953	Remove thigh pressure sore	Y		A2	15.9002	$666.84
15956	Remove thigh pressure sore	Y		A2	15.9002	$666.84
15958	Remove thigh pressure sore	Y		A2	15.9002	$666.84
16000	Initial treatment of burn(s)	Y		P3		$25.01

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16020	Dress/debrid p-thick burn s	Y		P3		$38.03
16025	Dress/debrid p-thick burn m	Y		A2	1.3834	$58.02
16030	Dress/debrid p-thick burn l	Y		A2	1.3834	$58.02
16035	Incision of burn scab initi	Y		G2	1.3834	$58.02
17000	Destruct premalg lesion	Y		P2	0.8409	$35.27
17003	Destruct premalg les 2-14	Y		P3		$3.32
17004	Destroy premlg lesions 15+	Y		P3		$75.29
17106	Destruction of skin lesions	Y		P2	2.5236	$105.84
17107	Destruction of skin lesions	Y		P2	2.5236	$105.84
17108	Destruction of skin lesions	Y		P2	2.5236	$105.84
17110	Destruct b9 lesion 1-14	Y		P2	0.8409	$35.27
17111	Destruct lesion 15 or more	Y		P2	1.3834	$58.02
17250	Chemical cautery tissue	Y		P3		$41.86
17260	Destruction of skin lesions	Y		P3		$43.13
17261	Destruction of skin lesions	Y		P2	1.3834	$58.02
17262	Destruction of skin lesions	Y		P2	1.3834	$58.02
17263	Destruction of skin lesions	Y		P2	1.3834	$58.02
17264	Destruction of skin lesions	Y		P2	1.3834	$58.02
17266	Destruction of skin lesions	Y		P3		$103.36
17270	Destruction of skin lesions	Y		P2	1.3834	$58.02
17271	Destruction of skin lesions	Y		P2	1.3834	$58.02
17272	Destruction of skin lesions	Y		P2	1.3834	$58.02
17273	Destruction of skin lesions	Y		P3		$94.18
17274	Destruction of skin lesions	Y		P2	2.5236	$105.84
17276	Destruction of skin lesions	Y		P2	2.5236	$105.84
17280	Destruction of skin lesions	Y		P2	1.3834	$58.02
17281	Destruction of skin lesions	Y		P3		$80.39
17282	Destruction of skin lesions	Y		P3		$92.13
17283	Destruction of skin lesions	Y		P2	2.5236	$105.84
17284	Destruction of skin lesions	Y		P2	2.5236	$105.84
17286	Destruction of skin lesions	Y		P2	2.5236	$105.84
17311	Mohs 1 stage h/n/hf/g	Y		P2	4.9576	$207.92
17312	Mohs addl stage	Y		P3		$204.68
17313	Mohs 1 stage t/a/l	Y		P2	4.9576	$207.92
17314	Mohs addl stage t/a/l	Y		P3		$189.63
17315	Mohs surg addl block	Y		P3		$35.22

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17340	Cryotherapy of skin	Y		P3		$14.80
17360	Skin peel therapy	Y		P2	0.8409	$35.27
17380	Hair removal by electrolysis	Y		R2	0.8409	$35.27
19000	Drainage of breast lesion	Y		P3		$57.93
19001	Drain breast lesion add-on	Y		P3		$7.91
19020	Incision of breast lesion	Y		A2	18.6604	$782.60
19030	Injection for breast x-ray	N		N1		
19100	Bx breast percut w/o image	Y		A2	4.235	$177.61
19101	Biopsy of breast open	Y		A2	23.641	$991.48
19102	Bx breast percut w/image	Y		A2	7.5162	$315.22
19103	Bx breast percut w/device	Y		A2	14.5045	$608.30
19105	Cryosurg ablate fa each	Y		P2	31.3402	$1,314.38
19110	Nipple exploration	Y		A2	23.641	$991.48
19112	Excise breast duct fistula	Y		A2	23.641	$991.48
19120	Removal of breast lesion	Y		A2	23.641	$991.48
19125	Excision breast lesion	Y		A2	23.641	$991.48
19126	Excision addl breast lesion	Y		A2	23.641	$991.48
19290	Place needle wire breast	N		N1		
19291	Place needle wire breast	N		N1		
19295	Place breast clip percut	N		N1		
19296	Place po breast cath for rad	Y		A2	59.115	$2,479.22
19297	Place breast cath for rad	Y		A2	59.115	$2,479.22
19298	Place breast rad tube/caths	Y		A2	59.115	$2,479.22
19300	Removal of breast tissue	Y		A2	23.641	$991.48
19301	Partical mastectomy	Y		A2	23.641	$991.48
19302	P-mastectomy w/ln removal	Y		A2	41.5736	$1,743.56
19303	Mast simple complete	Y		A2	31.3402	$1,314.38
19304	Mast subq	Y		A2	31.3402	$1,314.38
19316	Suspension of breast	Y		A2	31.3402	$1,314.38
19318	Reduction of large breast	Y		A2	41.5736	$1,743.56
19324	Enlarge breast	Y		A2	41.5736	$1,743.56
19325	Enlarge breast with implant	Y		A2	59.115	$2,479.22
19328	Removal of breast implant	Y		A2	31.3402	$1,314.38
19330	Removal of implant material	Y		A2	31.3402	$1,314.38
19340	Immediate breast prosthesis	Y		A2	41.5736	$1,743.56
19342	Delayed breast prosthesis	Y		A2	59.115	$2,479.22

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
19350	Breast reconstruction	Y		A2	23.641	$991.48
19355	Correct inverted nipple(s)	Y		A2	31.3402	$1,314.38
19357	Breast reconstruction	Y		A2	59.115	$2,479.22
19366	Breast reconstruction	Y		A2	31.3402	$1,314.38
19370	Surgery of breast capsule	Y		A2	31.3402	$1,314.38
19371	Removal of breast capsule	Y		A2	31.3402	$1,314.38
19380	Revise breast reconstruction	Y		A2	41.5736	$1,743.56
19396	Design custom breast implant	Y		G2	31.3402	$1,314.38
20000	Incision of abscess	N	CH	D5		
20005	I&d abscess subfascial	Y	NI	A2	7.8457	$329.04
20103	Explore wound extremity	Y		G2	12.0213	$504.16
20150	Excise epiphyseal bar	Y		G2	43.7154	$1,833.38
20200	Muscle biopsy	Y		A2	16.7008	$700.41
20205	Deep muscle biopsy	Y		A2	16.7008	$700.41
20206	Needle biopsy muscle	Y		A2	7.5162	$315.22
20220	Bone biopsy trocar/needle	Y		A2	7.8457	$329.04
20225	Bone biopsy trocar/needle	Y		A2	16.7008	$700.41
20240	Bone biopsy excisional	Y		A2	22.0775	$925.91
20245	Bone biopsy excisional	Y		A2	22.0775	$925.91
20250	Open bone biopsy	Y		A2	21.2238	$890.10
20251	Open bone biopsy	Y		A2	21.2238	$890.10
20500	Injection of sinus tract	Y		P3		$46.19
20501	Inject sinus tract for x-ray	N		N1		
20520	Removal of foreign body	Y		P3		$88.05
20525	Removal of foreign body	Y		A2	22.0775	$925.91
20526	Ther injection carp tunnel	Y		P3		$28.07
20550	Inj tendon sheath/ligament	Y		P3		$21.18
20551	Inj tendon origin/insertion	Y		P3		$21.69
20552	Inj trigger point 1/2 muscl	Y		P3		$20.67
20553	Inject trigger points =/> 3	Y		P3		$23.74
20555	Place ndl musc/tis for rt	Y		R2	29.7869	$1,249.23
20600	Drain/inject joint/bursa	Y		P3		$21.44
20605	Drain/inject joint/bursa	Y		P3		$24.25
20610	Drain/inject joint/bursa	Y		P3		$34.71
20612	Aspirate/inj ganglion cyst	Y		P3		$23.48
20615	Treatment of bone cyst	Y		P3		$94.43

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
20650	Insert and remove bone pin	Y		A2	21.2238	$890.10
20662	Application of pelvis brace	Y		R2	21.2238	$890.10
20663	Application of thigh brace	Y		R2	21.2238	$890.10
20665	Removal of fixation device	N		G2	0.6201	$26.01
20670	Removal of support implant	Y		A2	16.7008	$700.41
20680	Removal of support implant	Y		A2	22.0775	$925.91
20690	Apply bone fixation device	Y		A2	29.7869	$1,249.23
20692	Apply bone fixation device	Y		A2	29.7869	$1,249.23
20693	Adjust bone fixation device	Y		A2	21.2238	$890.10
20694	Remove bone fixation device	Y		A2	21.2238	$890.10
20696	Comp multiplane ext fixation	Y		G2	29.7869	$1,249.23
20697	Comp ext fixate strut change	Y	CH	P2	19.2479	$807.24
20822	Replantation digit complete	Y		G2	27.5002	$1,153.33
20900	Removal of bone for graft	Y		A2	29.7869	$1,249.23
20902	Removal of bone for graft	Y		A2	29.7869	$1,249.23
20910	Remove cartilage for graft	Y		A2	20.5842	$863.28
20912	Remove cartilage for graft	Y		A2	20.5842	$863.28
20920	Removal of fascia for graft	Y		A2	15.9002	$666.84
20922	Removal of fascia for graft	Y		A2	15.9002	$666.84
20924	Removal of tendon for graft	Y		A2	29.7869	$1,249.23
20926	Removal of tissue for graft	Y		A2	4.2885	$179.86
20950	Fluid pressure muscle	Y		G2	1.377	$57.75
20972	Bone/skin graft metatarsal	Y		G2	51.0472	$2,140.87
20973	Bone/skin graft great toe	Y		R2	51.0472	$2,140.87
20975	Electrical bone stimulation	N		N1		
20979	Us bone stimulation	N		P3		$20.93
20982	Ablate bone tumor(s) perq	Y		G2	43.7154	$1,833.38
20985	Cptr-asst dir ms px	N		N1		
21010	Incision of jaw joint	Y		A2	23.6929	$993.66
21011	Exc face les sc < 2 cm	Y		P3		$160.02
21012	Exc face les sbq 2+ cm	Y		R2	7.8457	$329.04
21013	Exc face tum deep < 2 cm	Y		P3		$223.31
21014	Exc face tum deep 2+ cm	Y		R2	7.8457	$329.04
21015*	Resect face tum < 2 cm	Y		R2	16.7008	$700.41
21016	Resect face tum + cm	Y		G2	22.0775	$925.91
21025	Excision of bone lower jaw	Y		A2	41.2845	$1,731.43

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
21026	Excision of facial bone(s)	Y		A2	41.2845	$1,731.43
21029	Contour of face bone lesion	Y		A2	41.2845	$1,731.43
21030	Excise max/zygoma b9 tumor	Y		P3		$233.52
21031	Remove exostosis mandible	Y		P3		$190.14
21032	Remove exostosis maxilla	Y		P3		$193.71
21034	Excise max/zygoma mlg tumor	Y		A2	41.2845	$1,731.43
21040	Excise mandible lesion	Y		A2	23.6929	$993.66
21044	Removal of jaw bone lesion	Y		A2	41.2845	$1,731.43
21046	Remove mandible cyst complex	Y		A2	41.2845	$1,731.43
21047	Excise lwr jaw cyst w/repair	Y		A2	41.2845	$1,731.43
21048	Remove maxilla cyst complex	Y		R2	41.2845	$1,731.43
21050	Removal of jaw joint	Y		A2	41.2845	$1,731.43
21060	Remove jaw joint cartilage	Y		A2	41.2845	$1,731.43
21070	Remove coronoid process	Y		A2	41.2845	$1,731.43
21073	Mnpj of tmj w/anesth	Y		P3		$182.74
21076	Prepare face/oral prosthesis	Y		P3		$339.95
21077	Prepare face/oral prosthesis	Y		P3		$836.60
21079	Prepare face/oral prosthesis	Y		P3		$584.70
21080	Prepare face/oral prosthesis	Y		P3		$663.82
21081	Prepare face/oral prosthesis	Y		P3		$613.54
21082	Prepare face/oral prosthesis	Y		P3		$593.12
21083	Prepare face/oral prosthesis	Y		P3		$581.13
21084	Prepare face/oral prosthesis	Y		P3		$659.23
21085	Prepare face/oral prosthesis	Y		P3		$277.42
21086	Prepare face/oral prosthesis	Y		P3		$610.48
21087	Prepare face/oral prosthesis	Y		P3		$607.93
21088	Prepare face/oral prosthesis	Y		R2	41.2845	$1,731.43
21100	Maxillofacial fixation	Y		A2	41.2845	$1,731.43
21110	Interdental fixation	Y		P2	7.3159	$306.82
21116	Injection jaw joint x-ray	N		N1		
21120	Reconstruction of chin	Y		A2	23.6929	$993.66
21121	Reconstruction of chin	Y		A2	23.6929	$993.66
21122	Reconstruction of chin	Y		A2	23.6929	$993.66
21123	Reconstruction of chin	Y		A2	23.6929	$993.66
21125	Augmentation lower jaw bone	Y		A2	23.6929	$993.66

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21127	Augmentation lower jaw bone	Y		A2	41.2845	$1,731.43
21137	Reduction of forehead	Y		G2	23.6929	$993.66
21138	Reduction of forehead	Y		G2	41.2845	$1,731.43
21139	Reduction of forehead	Y		G2	41.2845	$1,731.43
21150	Reconstruct midface lefort	Y		G2	41.2845	$1,731.43
21181	Contour cranial bone lesion	Y		A2	23.6929	$993.66
21198	Reconstr lwr jaw segment	Y		G2	41.2845	$1,731.43
21199	Reconstr lwr jaw w/advance	Y		G2	41.2845	$1,731.43
21206	Reconstruct upper jaw bone	Y		A2	41.2845	$1,731.43
21208	Augmentation of facial bones	Y		A2	41.2845	$1,731.43
21209	Reduction of facial bones	Y		A2	41.2845	$1,731.43
21210	Face bone graft	Y		A2	41.2845	$1,731.43
21215	Lower jaw bone graft	Y		A2	41.2845	$1,731.43
21230	Rib cartilage graft	Y		A2	41.2845	$1,731.43
21235	Ear cartilage graft	Y		A2	23.6929	$993.66
21240	Reconstruction of jaw joint	Y		A2	41.2845	$1,731.43
21242	Reconstruction of jaw joint	Y		A2	41.2845	$1,731.43
21243	Reconstruction of jaw joint	Y		A2	41.2845	$1,731.43
21244	Reconstruction of lower jaw	Y		A2	41.2845	$1,731.43
21245	Reconstruction of jaw	Y		A2	41.2845	$1,731.43
21246	Reconstruction of jaw	Y		A2	41.2845	$1,731.43
21248	Reconstruction of jaw	Y		A2	41.2845	$1,731.43
21249	Reconstruction of jaw	Y		A2	41.2845	$1,731.43
21260	Revise eye sockets	Y		G2	41.2845	$1,731.43
21267	Revise eye sockets	Y		A2	41.2845	$1,731.43
21270	Augmentation cheek bone	Y		A2	41.2845	$1,731.43
21275	Revision orbitofacial bones	Y		A2	41.2845	$1,731.43
21280	Revision of eyelid	Y		A2	41.2845	$1,731.43
21282	Revision of eyelid	Y		A2	16.0176	$671.76
21295	Revision of jaw muscle/bone	Y		A2	7.3159	$306.82
21296	Revision of jaw muscle/bone	Y		A2	23.6929	$993.66
21310	Treatment of nose fracture	Y		A2	1.0468	$43.90
21315	Treatment of nose fracture	Y		A2	16.0176	$671.76
21320	Treatment of nose fracture	Y		A2	16.0176	$671.76
21325	Treatment of nose fracture	Y		A2	23.6929	$993.66
21330	Treatment of nose fracture	Y		A2	23.6929	$993.66

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21335	Treatment of nose fracture	Y		A2	23.6929	$993.66
21336	Treat nasal septal fracture	Y		A2	24.5309	$1,028.80
21337	Treat nasal septal fracture	Y		A2	16.0176	$671.76
21338	Treat nasoethmoid fracture	Y		A2	23.6929	$993.66
21339	Treat nasoethmoid fracture	Y		A2	23.6929	$993.66
21340	Treatment of nose fracture	Y		A2	41.2845	$1,731.43
21345	Treat nose/jaw fracture	Y		A2	23.6929	$993.66
21355	Treat cheek bone fracture	Y		A2	41.2845	$1,731.43
21356	Treat cheek bone fracture	Y		A2	23.6929	$993.66
21360	Treat cheek bone fracture	Y		G2	23.6929	$993.66
21390	Treat eye socket fracture	Y		G2	41.2845	$1,731.43
21400	Treat eye socket fracture	Y		A2	7.3159	$306.82
21401	Treat eye socket fracture	Y		A2	16.0176	$671.76
21406	Treat eye socket fracture	Y		G2	41.2845	$1,731.43
21407	Treat eye socket fracture	Y		G2	41.2845	$1,731.43
21421	Treat mouth roof fracture	Y		A2	23.6929	$993.66
21440	Treat dental ridge fracture	Y		P3		$308.81
21445	Treat dental ridge fracture	Y		A2	23.6929	$993.66
21450	Treat lower jaw fracture	Y		A2	3.283	$137.69
21451	Treat lower jaw fracture	Y		A2	7.3159	$306.82
21452	Treat lower jaw fracture	Y		A2	16.0176	$671.76
21453	Treat lower jaw fracture	Y		A2	41.2845	$1,731.43
21454	Treat lower jaw fracture	Y		A2	23.6929	$993.66
21461	Treat lower jaw fracture	Y		A2	41.2845	$1,731.43
21462	Treat lower jaw fracture	Y		A2	41.2845	$1,731.43
21465	Treat lower jaw fracture	Y		A2	41.2845	$1,731.43
21480	Reset dislocated jaw	Y		A2	1.0468	$43.90
21485	Reset dislocated jaw	Y		A2	16.0176	$671.76
21490	Repair dislocated jaw	Y		A2	41.2845	$1,731.43
21495	Treat hyoid bone fracture	Y		G2	16.0176	$671.76
21497	Interdental wiring	Y		A2	16.0176	$671.76
21501	Drain neck/chest lesion	Y		A2	18.6604	$782.60
21502	Drain chest lesion	Y		A2	21.2238	$890.10
21550	Biopsy of neck/chest	Y		G2	16.7008	$700.41
21552	Exc neck les sc 3+ cm	Y		G2	22.0775	$925.91
21554	Exc neck tum deep 5+ cm	Y		G2	22.0775	$925.91

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21555*	Exc neck les sc < 3 cm	Y		P3		$185.29
21556	Exc neck tum deep < 5 cm	Y		G2	22.0775	$925.91
21557	Resect neck tum < 5 cm	Y		G2	16.7008	$700.41
21558	Resect neck tum 5+ cm	Y		G2	22.0775	$925.91
21600	Partial removal of rib	Y		A2	29.7869	$1,249.23
21610	Partial removal of rib	Y		A2	29.7869	$1,249.23
21685	Hyoid myotomy & suspension	Y		G2	7.3159	$306.82
21700	Revision of neck muscle	Y		A2	21.2238	$890.10
21720	Revision of neck muscle	Y		A2	21.2238	$890.10
21725	Revision of neck muscle	Y		A2	1.377	$57.75
21800	Treatment of rib fracture	Y		A2	1.4584	$61.16
21805	Treatment of rib fracture	Y		A2	24.5309	$1,028.80
21820	Treat sternum fracture	Y		A2	1.4584	$61.16
21920	Biopsy soft tissue of back	Y		P3		$129.91
21925	Biopsy soft tissue of back	Y		A2	22.0775	$925.91
21930*	Exc back les sc < 3 cm	Y		P3		$193.20
21931	Exc back les sc 3+ cm	Y		G2	22.0775	$925.91
21932	Exc back tum deep < 5 cm	Y		G2	16.7008	$700.41
21933	Exc back tum deep 5+ cm	Y		G2	22.0775	$925.91
21935	Resect back tum < 5 cm	Y		G2	16.7008	$700.41
21936	Resect back tum 5+ cm	Y		G2	22.0775	$925.91
22102	Remove part lumbar vertebra	Y		G2	47.4256	$1,988.98
22103	Remove extra spine segment	Y		G2	47.4256	$1,988.98
22305	Treat spine process fracture	Y		A2	1.4584	$61.16
22310	Treat spine fracture	Y		A2	5.0855	$213.28
22315	Treat spine fracture	Y		A2	19.2479	$807.24
22505	Manipulation of spine	Y		A2	14.3662	$602.50
22520	Percut vertebroplasty thor	Y		A2	29.7869	$1,249.23
22521	Percut vertebroplasty lumb	Y		A2	29.7869	$1,249.23
22522	Percut vertebroplasty addl	Y		A2	29.7869	$1,249.23
22523	Percut kyphoplasty thor	Y		G2	82.2061	$3,447.64
22524	Percut kyphoplasty lumbar	Y		G2	82.2061	$3,447.64
22525	Percut kyphoplasty add-on	Y		G2	82.2061	$3,447.64
22900	Exc back tum deep < 5 cm	Y		G2	22.0775	$925.91
22901	Exc back tum deep 5+ cm	Y		G2	22.0775	$925.91
22902	Exc abd les sc < 3 cm	Y		G2	16.7008	$700.41

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
22903	Exc abd les sc > 3 cm	Y		G2	22.0775	$925.91
22904	Resect abd tum < 5 cm	Y		G2	16.7008	$700.41
22905	Resect abd tum > 5 cm	Y		G2	22.0775	$925.91
23000	Removal of calcium deposits	Y		A2	16.7008	$700.41
23020	Release shoulder joint	Y		A2	43.7154	$1,833.38
23030	Drain shoulder lesion	Y		A2	18.6604	$782.60
23031	Drain shoulder bursa	Y		A2	18.6604	$782.60
23035	Drain shoulder bone lesion	Y		A2	21.2238	$890.10
23040	Exploratory shoulder surgery	Y		A2	29.7869	$1,249.23
23044	Exploratory shoulder surgery	Y		A2	29.7869	$1,249.23
23065	Biopsy shoulder tissues	Y		P3		$91.62
23066	Biopsy shoulder tissues	Y		A2	22.0775	$925.91
23071	Exc shoulder les sc > 3 cm	Y		G2	22.0775	$925.91
23073	Exc shoulder tum deep > 5 cm	Y		G2	22.0775	$925.91
23075*	Exc shoulder les sc < 3 cm	Y		P3		$167.17
23076	Exc shoulder tum deep < 5 cm	Y		G2	16.7008	$700.41
23077	Resect shoulder tum < 5 cm	Y		G2	16.7008	$700.41
23078	Resect shoulder tum > 5 cm	Y		G2	22.0775	$925.91
23100	Biopsy of shoulder joint	Y		A2	21.2238	$890.10
23101	Shoulder joint surgery	Y		A2	29.7869	$1,249.23
23105	Remove shoulder joint lining	Y		A2	29.7869	$1,249.23
23106	Incision of collarbone joint	Y		A2	29.7869	$1,249.23
23107	Explore treat shoulder joint	Y		A2	29.7869	$1,249.23
23120	Partial removal collar bone	Y		A2	29.7869	$1,249.23
23125	Removal of collar bone	Y		A2	29.7869	$1,249.23
23130	Remove shoulder bone part	Y		A2	43.7154	$1,833.38
23140	Removal of bone lesion	Y		A2	21.2238	$890.10
23145	Removal of bone lesion	Y		A2	29.7869	$1,249.23
23146	Removal of bone lesion	Y		A2	29.7869	$1,249.23
23150	Removal of humerus lesion	Y		A2	29.7869	$1,249.23
23155	Removal of humerus lesion	Y		A2	29.7869	$1,249.23
23156	Removal of humerus lesion	Y		A2	29.7869	$1,249.23
23170	Remove collar bone lesion	Y		A2	29.7869	$1,249.23
23172	Remove shoulder blade lesion	Y		A2	29.7869	$1,249.23

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23174	Remove humerus lesion	Y		A2	29.7869	$1,249.23
23180	Remove collar bone lesion	Y		A2	29.7869	$1,249.23
23182	Remove shoulder blade lesion	Y		A2	29.7869	$1,249.23
23184	Remove humerus lesion	Y		A2	29.7869	$1,249.23
23190	Partial removal of scapula	Y		A2	29.7869	$1,249.23
23195	Removal of head of humerus	Y		A2	29.7869	$1,249.23
23330	Remove shoulder foreign body	Y		A2	7.8457	$329.04
23331	Remove shoulder foreign body	Y		A2	22.0775	$925.91
23350	Injection for shoulder x-ray	N		N1		
23395	Muscle transfer shoulder/arm	Y		A2	43.7154	$1,833.38
23397	Muscle transfers	Y		A2	82.2061	$3,447.64
23400	Fixation of shoulder blade	Y		A2	29.7869	$1,249.23
23405	Incision of tendon & muscle	Y		A2	29.7869	$1,249.23
23406	Incise tendon(s) & muscle(s)	Y		A2	29.7869	$1,249.23
23410	Repair rotator cuff acute	Y		A2	43.7154	$1,833.38
23412	Repair rotator cuff chronic	Y		A2	43.7154	$1,833.38
23415	Release of shoulder ligament	Y		A2	43.7154	$1,833.38
23420	Repair of shoulder	Y		A2	43.7154	$1,833.38
23430	Repair biceps tendon	Y		A2	43.7154	$1,833.38
23440	Remove/transplant tendon	Y		A2	43.7154	$1,833.38
23450	Repair shoulder capsule	Y		A2	82.2061	$3,447.64
23455	Repair shoulder capsule	Y		A2	82.2061	$3,447.64
23460	Repair shoulder capsule	Y		A2	82.2061	$3,447.64
23462	Repair shoulder capsule	Y		A2	43.7154	$1,833.38
23465	Repair shoulder capsule	Y		A2	82.2061	$3,447.64
23466	Repair shoulder capsule	Y		A2	43.7154	$1,833.38
23480	Revision of collar bone	Y		A2	43.7154	$1,833.38
23485	Revision of collar bone	Y		A2	82.2061	$3,447.64
23490	Reinforce clavicle	Y		A2	82.2061	$3,447.64
23491	Reinforce shoulder bones	Y		A2	82.2061	$3,447.64
23500	Treat clavicle fracture	Y		A2	1.4584	$61.16
23505	Treat clavicle fracture	Y		A2	19.2479	$807.24
23515	Treat clavicle fracture	Y		A2	61.8075	$2,592.14
23520	Treat clavicle dislocation	Y		A2	5.0855	$213.28

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
23525	Treat clavicle dislocation	Y		A2	5.0855	$213.28
23530	Treat clavicle dislocation	Y		A2	44.4642	$1,864.78
23532	Treat clavicle dislocation	Y		A2	24.5309	$1,028.80
23540	Treat clavicle dislocation	Y		A2	1.4584	$61.16
23545	Treat clavicle dislocation	Y		A2	5.0855	$213.28
23550	Treat clavicle dislocation	Y		A2	44.4642	$1,864.78
23552	Treat clavicle dislocation	Y		A2	44.4642	$1,864.78
23570	Treat shoulder blade fx	Y		A2	1.4584	$61.16
23575	Treat shoulder blade fx	Y		A2	5.0855	$213.28
23585	Treat scapula fracture	Y		A2	61.8075	$2,592.14
23600	Treat humerus fracture	Y		P2	1.4584	$61.16
23605	Treat humerus fracture	Y		A2	19.2479	$807.24
23615	Treat humerus fracture	Y		A2	61.8075	$2,592.14
23616	Treat humerus fracture	Y		A2	61.8075	$2,592.14
23620	Treat humerus fracture	Y		P2	1.4584	$61.16
23625	Treat humerus fracture	Y		A2	19.2479	$807.24
23630	Treat humerus fracture	Y		A2	61.8075	$2,592.14
23650	Treat shoulder dislocation	Y		A2	1.4584	$61.16
23655	Treat shoulder dislocation	Y		A2	14.3662	$602.50
23660	Treat shoulder dislocation	Y		A2	44.4642	$1,864.78
23665	Treat dislocation/fracture	Y		A2	5.0855	$213.28
23670	Treat dislocation/fracture	Y		A2	61.8075	$2,592.14
23675	Treat dislocation/fracture	Y		A2	1.4584	$61.16
23680	Treat dislocation/fracture	Y		A2	44.4642	$1,864.78
23700	Fixation of shoulder	Y		A2	14.3662	$602.50
23800	Fusion of shoulder joint	Y		A2	82.2061	$3,447.64
23802	Fusion of shoulder joint	Y		A2	82.2061	$3,447.64
23921	Amputation follow-up surgery	Y		A2	15.9002	$666.84
23930	Drainage of arm lesion	Y		A2	18.6604	$782.60
23931	Drainage of arm bursa	Y		A2	18.6604	$782.60
23935	Drain arm/elbow bone lesion	Y		A2	21.2238	$890.10
24000	Exploratory elbow surgery	Y		A2	29.7869	$1,249.23
24006	Release elbow joint	Y		A2	29.7869	$1,249.23
24065	Biopsy arm/elbow soft tissue	Y		P3		$126.08
24066	Biopsy arm/elbow soft tissue	Y		A2	16.7008	$700.41
24071	Exc arm/elbow les sc 3+ cm	Y		G2	22.0775	$925.91

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
24073	Ex arm/elbow tum deep > 5 cm	Y		G2	22.0775	$925.91
24075*	Exc arm/elbow les sc < 3 cm	Y		P3		$229.95
24076	Ex arm/elbow tum deep < 5 cm	Y		G2	16.7008	$700.41
24077	Resect arm/elbow tum < 5 cm	Y		G2	16.7008	$700.41
24079	Resect arm/elbow tum > 5 cm	Y		G2	22.0775	$925.91
24100	Biopsy elbow joint lining	Y		A2	21.2238	$890.10
24101	Explore/treat elbow joint	Y		A2	29.7869	$1,249.23
24102	Remove elbow joint lining	Y		A2	29.7869	$1,249.23
24105	Removal of elbow bursa	Y		A2	21.2238	$890.10
24110	Remove humerus lesion	Y		A2	21.2238	$890.10
24115	Remove/graft bone lesion	Y		A2	29.7869	$1,249.23
24116	Remove/graft bone lesion	Y		A2	29.7869	$1,249.23
24120	Remove elbow lesion	Y		A2	21.2238	$890.10
24125	Remove/graft bone lesion	Y		A2	29.7869	$1,249.23
24126	Remove/graft bone lesion	Y		A2	29.7869	$1,249.23
24130	Removal of head of radius	Y		A2	29.7869	$1,249.23
24134	Removal of arm bone lesion	Y		A2	29.7869	$1,249.23
24136	Remove radius bone lesion	Y		A2	29.7869	$1,249.23
24138	Remove elbow bone lesion	Y		A2	29.7869	$1,249.23
24140	Partial removal of arm bone	Y		A2	29.7869	$1,249.23
24145	Partial removal of radius	Y		A2	29.7869	$1,249.23
24147	Partial removal of elbow	Y		A2	29.7869	$1,249.23
24149	Radical resection of elbow	Y		G2	29.7869	$1,249.23
24152	Resect radius tumor	Y		G2	43.7154	$1,833.38
24155	Removal of elbow joint	Y		A2	43.7154	$1,833.38
24160	Remove elbow joint implant	Y		A2	29.7869	$1,249.23
24164	Remove radius head implant	Y		A2	29.7869	$1,249.23
24200	Removal of arm foreign body	Y		P3		$94.18
24201	Removal of arm foreign body	Y		A2	16.7008	$700.41
24220	Injection for elbow x-ray	N		N1		
24300	Manipulate elbow w/anesth	Y		G2	14.3662	$602.50
24301	Muscle/tendon transfer	Y		A2	29.7869	$1,249.23
24305	Arm tendon lengthening	Y		A2	29.7869	$1,249.23
24310	Revision of arm tendon	Y		A2	21.2238	$890.10
24320	Repair of arm tendon	Y		A2	43.7154	$1,833.38

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
24330	Revision of arm muscles	Y		A2	82.2061	$3,447.64
24331	Revision of arm muscles	Y		A2	43.7154	$1,833.38
24332	Tenolysis triceps	Y		G2	21.2238	$890.10
24340	Repair of biceps tendon	Y		A2	43.7154	$1,833.38
24341	Repair arm tendon/muscle	Y		A2	43.7154	$1,833.38
24342	Repair of ruptured tendon	Y		A2	43.7154	$1,833.38
24343	Repr elbow lat ligmnt w/tiss	Y		G2	29.7869	$1,249.23
24344	Reconstruct elbow lat ligmnt	Y		G2	82.2061	$3,447.64
24345	Repr elbw med ligmnt w/tissu	Y		A2	29.7869	$1,249.23
24346	Reconstruct elbow med ligmnt	Y		G2	82.2061	$3,447.64
24357	Repair elbow perc	Y		G2	29.7869	$1,249.23
24358	Repair elbow w/deb open	Y		G2	29.7869	$1,249.23
24359	Repair elbow deb/attch open	Y		G2	29.7869	$1,249.23
24360	Reconstruct elbow joint	Y		A2	36.2919	$1,522.05
24361	Reconstruct elbow joint	Y		H8	168.536	$7,068.23
24362	Reconstruct elbow joint	Y		A2	55.3881	$2,322.92
24363	Replace elbow joint	Y		H8	168.536	$7,068.23
24365	Reconstruct head of radius	Y		A2	36.2919	$1,522.05
24366	Reconstruct head of radius	Y		H8	168.536	$7,068.23
24400	Revision of humerus	Y		A2	82.2061	$3,447.64
24410	Revision of humerus	Y		A2	43.7154	$1,833.38
24420	Revision of humerus	Y		A2	43.7154	$1,833.38
24430	Repair of humerus	Y		A2	82.2061	$3,447.64
24435	Repair humerus with graft	Y		A2	82.2061	$3,447.64
24470	Revision of elbow joint	Y		A2	43.7154	$1,833.38
24495	Decompression of forearm	Y		A2	29.7869	$1,249.23
24498	Reinforce humerus	Y		A2	82.2061	$3,447.64
24500	Treat humerus fracture	Y		A2	1.4584	$61.16
24505	Treat humerus fracture	Y		A2	1.4584	$61.16
24515	Treat humerus fracture	Y		A2	61.8075	$2,592.14
24516	Treat humerus fracture	Y		A2	61.8075	$2,592.14
24530	Treat humerus fracture	Y		A2	1.4584	$61.16
24535	Treat humerus fracture	Y		A2	5.0855	$213.28
24538	Treat humerus fracture	Y		A2	24.5309	$1,028.80
24545	Treat humerus fracture	Y		A2	61.8075	$2,592.14
24546	Treat humerus fracture	Y		A2	61.8075	$2,592.14

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
24560	Treat humerus fracture	Y		A2	1.4584	$61.16
24565	Treat humerus fracture	Y		A2	1.4584	$61.16
24566	Treat humerus fracture	Y		A2	24.5309	$1,028.80
24575	Treat humerus fracture	Y		A2	61.8075	$2,592.14
24576	Treat humerus fracture	Y		A2	1.4584	$61.16
24577	Treat humerus fracture	Y		A2	1.4584	$61.16
24579	Treat humerus fracture	Y		A2	61.8075	$2,592.14
24582	Treat humerus fracture	Y		A2	24.5309	$1,028.80
24586	Treat elbow fracture	Y		A2	61.8075	$2,592.14
24587	Treat elbow fracture	Y		A2	61.8075	$2,592.14
24600	Treat elbow dislocation	Y		A2	1.4584	$61.16
24605	Treat elbow dislocation	Y		A2	14.3662	$602.50
24615	Treat elbow dislocation	Y		A2	61.8075	$2,592.14
24620	Treat elbow fracture	Y		A2	19.2479	$807.24
24635	Treat elbow fracture	Y		A2	61.8075	$2,592.14
24640	Treat elbow dislocation	Y		P3		$54.62
24650	Treat radius fracture	Y		P2	1.4584	$61.16
24655	Treat radius fracture	Y		A2	5.0855	$213.28
24665	Treat radius fracture	Y		A2	44.4642	$1,864.78
24666	Treat radius fracture	Y		A2	61.8075	$2,592.14
24670	Treat ulnar fracture	Y		A2	1.4584	$61.16
24675	Treat ulnar fracture	Y		A2	1.4584	$61.16
24685	Treat ulnar fracture	Y		A2	44.4642	$1,864.78
24800	Fusion of elbow joint	Y		A2	43.7154	$1,833.38
24802	Fusion/graft of elbow joint	Y		A2	82.2061	$3,447.64
24925	Amputation follow-up surgery	Y		A2	21.2238	$890.10
25000	Incision of tendon sheath	Y		A2	21.2238	$890.10
25001	Incise flexor carpi radialis	Y		G2	21.2238	$890.10
25020	Decompress forearm 1 space	Y		A2	29.7869	$1,249.23
25023	Decompress forearm 1 space	Y		A2	29.7869	$1,249.23
25024	Decompress forearm 2 spaces	Y		A2	29.7869	$1,249.23
25025	Decompress forearm 2 spaces	Y		A2	29.7869	$1,249.23
25028	Drainage of forearm lesion	Y		A2	21.2238	$890.10
25031	Drainage of forearm bursa	Y		A2	21.2238	$890.10
25035	Treat forearm bone lesion	Y		A2	21.2238	$890.10

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
25040	Explore/treat wrist joint	Y		A2	29.7869	$1,249.23
25065	Biopsy forearm soft tissues	Y		P3		$127.61
25066	Biopsy forearm soft tissues	Y		A2	22.0775	$925.91
25071	Exc forearm les sc > 3 cm	Y		G2	22.0775	$925.91
25073	Exc forearm tum deep 3+ cm	Y		G2	22.0775	$925.91
25075*	Exc forearm les sc < 3 cm	Y		P3		$235.57
25076	Exc forearm tum deep < 3 cm	Y		G2	16.7008	$700.41
25077	Resect forearm/wrist tum<3cm	Y		G2	16.7008	$700.41
25078	Resect forearm/wrist tum3+cm	Y		G2	22.0775	$925.91
25085	Incision of wrist capsule	Y		A2	21.2238	$890.10
25100	Biopsy of wrist joint	Y		A2	21.2238	$890.10
25101	Explore/treat wrist joint	Y		A2	29.7869	$1,249.23
25105	Remove wrist joint lining	Y		A2	29.7869	$1,249.23
25107	Remove wrist joint cartilage	Y		A2	29.7869	$1,249.23
25109	Excise tendon forearm/wrist	Y		G2	21.2238	$890.10
25110	Remove wrist tendon lesion	Y		A2	21.2238	$890.10
25111	Remove wrist tendon lesion	Y		A2	21.2238	$890.10
25112	Reremove wrist tendon lesion	Y		A2	21.2238	$890.10
25115	Remove wrist/forearm lesion	Y		A2	21.2238	$890.10
25116	Remove wrist/forearm lesion	Y		A2	21.2238	$890.10
25118	Excise wrist tendon sheath	Y		A2	29.7869	$1,249.23
25119	Partial removal of ulna	Y		A2	29.7869	$1,249.23
25120	Removal of forearm lesion	Y		A2	29.7869	$1,249.23
25125	Remove/graft forearm lesion	Y		A2	29.7869	$1,249.23
25126	Remove/graft forearm lesion	Y		A2	29.7869	$1,249.23
25130	Removal of wrist lesion	Y		A2	29.7869	$1,249.23
25135	Remove & graft wrist lesion	Y		A2	29.7869	$1,249.23
25136	Remove & graft wrist lesion	Y		A2	29.7869	$1,249.23
25145	Remove forearm bone lesion	Y		A2	29.7869	$1,249.23
25150	Partial removal of ulna	Y		A2	29.7869	$1,249.23
25151	Partial removal of radius	Y		A2	29.7869	$1,249.23
25210	Removal of wrist bone	Y		A2	29.7869	$1,249.23
25215	Removal of wrist bones	Y		A2	29.7869	$1,249.23
25230	Partial removal of radius	Y		A2	29.7869	$1,249.23
25240	Partial removal of ulna	Y		A2	29.7869	$1,249.23

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(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
25246	Injection for wrist x-ray	N		N1		
25248	Remove forearm foreign body	Y		A2	21.2238	$890.10
25250	Removal of wrist prosthesis	Y		A2	29.7869	$1,249.23
25251	Removal of wrist prosthesis	Y		A2	29.7869	$1,249.23
25259	Manipulate wrist w/anesthes	Y		G2	19.2479	$807.24
25260	Repair forearm tendon/muscle	Y		A2	29.7869	$1,249.23
25263	Repair forearm tendon/muscle	Y		A2	29.7869	$1,249.23
25265	Repair forearm tendon/muscle	Y		A2	29.7869	$1,249.23
25270	Repair forearm tendon/muscle	Y		A2	29.7869	$1,249.23
25272	Repair forearm tendon/muscle	Y		A2	29.7869	$1,249.23
25274	Repair forearm tendon/muscle	Y		A2	29.7869	$1,249.23
25275	Repair forearm tendon sheath	Y		A2	29.7869	$1,249.23
25280	Revise wrist/forearm tendon	Y		A2	29.7869	$1,249.23
25290	Incise wrist/forearm tendon	Y		A2	29.7869	$1,249.23
25295	Release wrist/forearm tendon	Y		A2	21.2238	$890.10
25300	Fusion of tendons at wrist	Y		A2	29.7869	$1,249.23
25301	Fusion of tendons at wrist	Y		A2	29.7869	$1,249.23
25310	Transplant forearm tendon	Y		A2	43.7154	$1,833.38
25312	Transplant forearm tendon	Y		A2	43.7154	$1,833.38
25315	Revise palsy hand tendon(s)	Y		A2	43.7154	$1,833.38
25316	Revise palsy hand tendon(s)	Y		A2	82.2061	$3,447.64
25320	Repair/revise wrist joint	Y		A2	43.7154	$1,833.38
25332	Revise wrist joint	Y		A2	36.2919	$1,522.05
25335	Realignment of hand	Y		A2	43.7154	$1,833.38
25337	Reconstruct ulna/radioulnar	Y		A2	43.7154	$1,833.38
25350	Revision of radius	Y		A2	43.7154	$1,833.38
25355	Revision of radius	Y		A2	43.7154	$1,833.38
25360	Revision of ulna	Y		A2	43.7154	$1,833.38
25365	Revise radius & ulna	Y		A2	82.2061	$3,447.64
25370	Revise radius or ulna	Y		A2	43.7154	$1,833.38
25375	Revise radius & ulna	Y		A2	43.7154	$1,833.38
25390	Shorten radius or ulna	Y		A2	43.7154	$1,833.38

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
25391	Lengthen radius or ulna	Y		A2	82.2061	$3,447.64
25392	Shorten radius & ulna	Y		A2	29.7869	$1,249.23
25393	Lengthen radius & ulna	Y		A2	43.7154	$1,833.38
25394	Repair carpal bone shorten	Y		G2	43.7154	$1,833.38
25400	Repair radius or ulna	Y		A2	82.2061	$3,447.64
25405	Repair/graft radius or ulna	Y		A2	82.2061	$3,447.64
25415	Repair radius & ulna	Y		A2	82.2061	$3,447.64
25420	Repair/graft radius & ulna	Y		A2	82.2061	$3,447.64
25425	Repair/graft radius or ulna	Y		A2	82.2061	$3,447.64
25426	Repair/graft radius & ulna	Y		A2	43.7154	$1,833.38
25430	Vasc graft into carpal bone	Y		G2	43.7154	$1,833.38
25431	Repair nonunion carpal bone	Y		G2	43.7154	$1,833.38
25440	Repair/graft wrist bone	Y		A2	82.2061	$3,447.64
25441	Reconstruct wrist joint	Y		H8	168.536	$7,068.23
25442	Reconstruct wrist joint	Y		H8	168.536	$7,068.23
25443	Reconstruct wrist joint	Y		A2	55.3881	$2,322.92
25444	Reconstruct wrist joint	Y		A2	55.3881	$2,322.92
25445	Reconstruct wrist joint	Y		A2	55.3881	$2,322.92
25446	Wrist replacement	Y		H8	168.536	$7,068.23
25447	Repair wrist joint(s)	Y		A2	36.2919	$1,522.05
25449	Remove wrist joint implant	Y		A2	36.2919	$1,522.05
25450	Revision of wrist joint	Y		A2	43.7154	$1,833.38
25455	Revision of wrist joint	Y		A2	43.7154	$1,833.38
25490	Reinforce radius	Y		A2	43.7154	$1,833.38
25491	Reinforce ulna	Y		A2	43.7154	$1,833.38
25492	Reinforce radius and ulna	Y		A2	43.7154	$1,833.38
25500	Treat fracture of radius	Y		P2	1.4584	$61.16
25505	Treat fracture of radius	Y		A2	5.0855	$213.28
25515	Treat fracture of radius	Y		A2	44.4642	$1,864.78
25520	Treat fracture of radius	Y		A2	5.0855	$213.28
25525	Treat fracture of radius	Y		A2	44.4642	$1,864.78
25526	Treat fracture of radius	Y		A2	44.4642	$1,864.78
25530	Treat fracture of ulna	Y		P2	1.4584	$61.16
25535	Treat fracture of ulna	Y		A2	1.4584	$61.16
25545	Treat fracture of ulna	Y		A2	44.4642	$1,864.78
25560	Treat fracture radius & ulna	Y		P2	1.4584	$61.16

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
25565	Treat fracture radius & ulna	Y		A2	5.0855	$213.28
25574	Treat fracture radius & ulna	Y		A2	61.8075	$2,592.14
25575	Treat fracture radius/ulna	Y		A2	61.8075	$2,592.14
25600	Treat fracture radius/ulna	Y		P2	1.4584	$61.16
25605	Treat fracture radius/ulna	Y		A2	5.0855	$213.28
25606	Treat fx distal radial	Y		A2	24.5309	$1,028.80
25607	Treat fx rad extra-articul	Y		A2	61.8075	$2,592.14
25608	Treat fx rad intra-articul	Y		A2	61.8075	$2,592.14
25609	Treat fx radial 3+ frag	Y		A2	61.8075	$2,592.14
25622	Treat wrist bone fracture	Y		P2	1.4584	$61.16
25624	Treat wrist bone fracture	Y		A2	5.0855	$213.28
25628	Treat wrist bone fracture	Y		A2	44.4642	$1,864.78
25630	Treat wrist bone fracture	Y		P2	1.4584	$61.16
25635	Treat wrist bone fracture	Y		A2	1.4584	$61.16
25645	Treat wrist bone fracture	Y		A2	44.4642	$1,864.78
25650	Treat wrist bone fracture	Y		P2	1.4584	$61.16
25651	Pin ulnar styloid fracture	Y		G2	24.5309	$1,028.80
25652	Treat fracture ulnar styloid	Y		G2	44.4642	$1,864.78
25660	Treat wrist dislocation	Y		A2	1.4584	$61.16
25670	Treat wrist dislocation	Y		A2	24.5309	$1,028.80
25671	Pin radioulnar dislocation	Y		A2	24.5309	$1,028.80
25675	Treat wrist dislocation	Y		A2	1.4584	$61.16
25676	Treat wrist dislocation	Y		A2	24.5309	$1,028.80
25680	Treat wrist fracture	Y		A2	1.4584	$61.16
25685	Treat wrist fracture	Y		A2	24.5309	$1,028.80
25690	Treat wrist dislocation	Y		A2	19.2479	$807.24
25695	Treat wrist dislocation	Y		A2	24.5309	$1,028.80
25800	Fusion of wrist joint	Y		A2	82.2061	$3,447.64
25805	Fusion/graft of wrist joint	Y		A2	82.2061	$3,447.64
25810	Fusion/graft of wrist joint	Y		A2	82.2061	$3,447.64
25820	Fusion of hand bones	Y		A2	43.7154	$1,833.38
25825	Fuse hand bones with graft	Y		A2	82.2061	$3,447.64
25830	Fusion radioulnar jnt/ulna	Y		A2	82.2061	$3,447.64
25907	Amputation follow-up surgery	Y		A2	21.2238	$890.10
25922	Amputate hand at wrist	Y		A2	21.2238	$890.10
25929	Amputation follow-up surgery	Y		A2	15.9002	$666.84

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
25931	Amputation follow-up surgery	Y		G2	21.2238	$890.10
26010	Drainage of finger abscess	Y		P2	1.377	$57.75
26011	Drainage of finger abscess	Y		A2	12.0213	$504.16
26020	Drain hand tendon sheath	Y		A2	15.8563	$665.00
26025	Drainage of palm bursa	Y		A2	15.8563	$665.00
26030	Drainage of palm bursa(s)	Y		A2	15.8563	$665.00
26034	Treat hand bone lesion	Y		A2	15.8563	$665.00
26035	Decompress fingers/hand	Y		G2	15.8563	$665.00
26037	Decompress fingers/hand	Y		G2	15.8563	$665.00
26040	Release palm contracture	Y		A2	15.8563	$665.00
26045	Release palm contracture	Y		A2	27.5002	$1,153.33
26055	Incise finger tendon sheath	Y		A2	15.8563	$665.00
26060	Incision of finger tendon	Y		A2	15.8563	$665.00
26070	Explore/treat hand joint	Y		A2	15.8563	$665.00
26075	Explore/treat finger joint	Y		A2	15.8563	$665.00
26080	Explore/treat finger joint	Y		A2	15.8563	$665.00
26100	Biopsy hand joint lining	Y		A2	15.8563	$665.00
26105	Biopsy finger joint lining	Y		A2	15.8563	$665.00
26110	Biopsy finger joint lining	Y		A2	15.8563	$665.00
26111	Exc hand les sc > 1.5 cm	Y		G2	22.0775	$925.91
26113	Exc hand tum deep > 1.5 cm	Y		G2	22.0775	$925.91
26115*	Exc hand les sc < 1.5 cm	Y		P3		$291.97
26116	Exc hand tum deep < 1.5 cm	Y		G2	16.7008	$700.41
26117	Exc hand tum ra < 3 cm	Y		G2	16.7008	$700.41
26118	Exc hand tum ra > 3 cm	Y		G2	22.0775	$925.91
26121	Release palm contracture	Y		A2	27.5002	$1,153.33
26123	Release palm contracture	Y		A2	27.5002	$1,153.33
26125	Release palm contracture	Y		A2	15.8563	$665.00
26130	Remove wrist joint lining	Y		A2	15.8563	$665.00
26135	Revise finger joint each	Y		A2	27.5002	$1,153.33
26140	Revise finger joint each	Y		A2	15.8563	$665.00
26145	Tendon excision palm/finger	Y		A2	15.8563	$665.00
26160	Remove tendon sheath lesion	Y		A2	15.8563	$665.00
26170	Removal of palm tendon each	Y		A2	15.8563	$665.00
26180	Removal of finger tendon	Y		A2	15.8563	$665.00
26185	Remove finger bone	Y		A2	15.8563	$665.00

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
26200	Remove hand bone lesion	Y		A2	15.8563	$665.00
26205	Remove/graft bone lesion	Y		A2	27.5002	$1,153.33
26210	Removal of finger lesion	Y		A2	15.8563	$665.00
26215	Remove/graft finger lesion	Y		A2	15.8563	$665.00
26230	Partial removal of hand bone	Y		A2	15.8563	$665.00
26235	Partial removal finger bone	Y		A2	15.8563	$665.00
26236	Partial removal finger bone	Y		A2	15.8563	$665.00
26250	Extensive hand surgery	Y		A2	15.8563	$665.00
26260	Resect prox finger tumor	Y		A2	15.8563	$665.00
26262	Resect distal finger tumor	Y		A2	15.8563	$665.00
26320	Removal of implant from hand	Y		A2	16.7008	$700.41
26340	Manipulate finger w/anesth	Y		G2	5.0855	$213.28
26350	Repair finger/hand tendon	Y		A2	27.5002	$1,153.33
26352	Repair/graft hand tendon	Y		A2	27.5002	$1,153.33
26356	Repair finger/hand tendon	Y		A2	27.5002	$1,153.33
26357	Repair finger/hand tendon	Y		A2	27.5002	$1,153.33
26358	Repair/graft hand tendon	Y		A2	27.5002	$1,153.33
26370	Repair finger/hand tendon	Y		A2	27.5002	$1,153.33
26372	Repair/graft hand tendon	Y		A2	27.5002	$1,153.33
26373	Repair finger/hand tendon	Y		A2	27.5002	$1,153.33
26390	Revise hand/finger tendon	Y		A2	27.5002	$1,153.33
26392	Repair/graft hand tendon	Y		A2	27.5002	$1,153.33
26410	Repair hand tendon	Y		A2	15.8563	$665.00
26412	Repair/graft hand tendon	Y		A2	27.5002	$1,153.33
26415	Excision hand/finger tendon	Y		A2	27.5002	$1,153.33
26416	Graft hand or finger tendon	Y		A2	27.5002	$1,153.33
26418	Repair finger tendon	Y		A2	15.8563	$665.00
26420	Repair/graft finger tendon	Y		A2	27.5002	$1,153.33
26426	Repair finger/hand tendon	Y		A2	27.5002	$1,153.33
26428	Repair/graft finger tendon	Y		A2	27.5002	$1,153.33
26432	Repair finger tendon	Y		A2	15.8563	$665.00
26433	Repair finger tendon	Y		A2	15.8563	$665.00
26434	Repair/graft finger tendon	Y		A2	27.5002	$1,153.33
26437	Realignment of tendons	Y		A2	15.8563	$665.00
26440	Release palm/finger tendon	Y		A2	15.8563	$665.00
26442	Release palm & finger tendon	Y		A2	27.5002	$1,153.33

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(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
26445	Release hand/finger tendon	Y		A2	15.8563	$665.00
26449	Release forearm/hand tendon	Y		A2	27.5002	$1,153.33
26450	Incision of palm tendon	Y		A2	15.8563	$665.00
26455	Incision of finger tendon	Y		A2	15.8563	$665.00
26460	Incise hand/finger tendon	Y		A2	15.8563	$665.00
26471	Fusion of finger tendons	Y		A2	15.8563	$665.00
26474	Fusion of finger tendons	Y		A2	15.8563	$665.00
26476	Tendon lengthening	Y		A2	15.8563	$665.00
26477	Tendon shortening	Y		A2	15.8563	$665.00
26478	Lengthening of hand tendon	Y		A2	15.8563	$665.00
26479	Shortening of hand tendon	Y		A2	15.8563	$665.00
26480	Transplant hand tendon	Y		A2	27.5002	$1,153.33
26483	Transplant/graft hand tendon	Y		A2	27.5002	$1,153.33
26485	Transplant palm tendon	Y		A2	27.5002	$1,153.33
26489	Transplant/graft palm tendon	Y		A2	27.5002	$1,153.33
26490	Revise thumb tendon	Y		A2	27.5002	$1,153.33
26492	Tendon transfer with graft	Y		A2	27.5002	$1,153.33
26494	Hand tendon/muscle transfer	Y		A2	27.5002	$1,153.33
26496	Revise thumb tendon	Y		A2	27.5002	$1,153.33
26497	Finger tendon transfer	Y		A2	27.5002	$1,153.33
26498	Finger tendon transfer	Y		A2	27.5002	$1,153.33
26499	Revision of finger	Y		A2	27.5002	$1,153.33
26500	Hand tendon reconstruction	Y		A2	15.8563	$665.00
26502	Hand tendon reconstruction	Y		A2	27.5002	$1,153.33
26508	Release thumb contracture	Y		A2	15.8563	$665.00
26510	Thumb tendon transfer	Y		A2	27.5002	$1,153.33
26516	Fusion of knuckle joint	Y		A2	27.5002	$1,153.33
26517	Fusion of knuckle joints	Y		A2	27.5002	$1,153.33
26518	Fusion of knuckle joints	Y		A2	27.5002	$1,153.33
26520	Release knuckle contracture	Y		A2	15.8563	$665.00
26525	Release finger contracture	Y		A2	15.8563	$665.00
26530	Revise knuckle joint	Y		A2	36.2919	$1,522.05
26531	Revise knuckle with implant	Y		A2	55.3881	$2,322.92
26535	Revise finger joint	Y		A2	36.2919	$1,522.05
26536	Revise/implant finger joint	Y		A2	55.3881	$2,322.92
26540	Repair hand joint	Y		A2	15.8563	$665.00

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
26541	Repair hand joint with graft	Y		A2	27.5002	$1,153.33
26542	Repair hand joint with graft	Y		A2	15.8563	$665.00
26545	Reconstruct finger joint	Y		A2	27.5002	$1,153.33
26546	Repair nonunion hand	Y		A2	27.5002	$1,153.33
26548	Reconstruct finger joint	Y		A2	27.5002	$1,153.33
26550	Construct thumb replacement	Y		A2	27.5002	$1,153.33
26555	Positional change of finger	Y		A2	27.5002	$1,153.33
26560	Repair of web finger	Y		A2	15.8563	$665.00
26561	Repair of web finger	Y		A2	27.5002	$1,153.33
26562	Repair of web finger	Y		A2	27.5002	$1,153.33
26565	Correct metacarpal flaw	Y		A2	27.5002	$1,153.33
26567	Correct finger deformity	Y		A2	27.5002	$1,153.33
26568	Lengthen metacarpal/finger	Y		A2	27.5002	$1,153.33
26580	Repair hand deformity	Y		A2	15.8563	$665.00
26587	Reconstruct extra finger	Y		A2	15.8563	$665.00
26590	Repair finger deformity	Y		A2	15.8563	$665.00
26591	Repair muscles of hand	Y		A2	27.5002	$1,153.33
26593	Release muscles of hand	Y		A2	15.8563	$665.00
26596	Excision constricting tissue	Y		A2	15.8563	$665.00
26600	Treat metacarpal fracture	Y		P2	1.4584	$61.16
26605	Treat metacarpal fracture	Y		A2	1.4584	$61.16
26607	Treat metacarpal fracture	Y		A2	19.2479	$807.24
26608	Treat metacarpal fracture	Y		A2	24.5309	$1,028.80
26615	Treat metacarpal fracture	Y		A2	44.4642	$1,864.78
26641	Treat thumb dislocation	Y		P2	1.4584	$61.16
26645	Treat thumb fracture	Y		A2	5.0855	$213.28
26650	Treat thumb fracture	Y		A2	24.5309	$1,028.80
26665	Treat thumb fracture	Y		A2	44.4642	$1,864.78
26670	Treat hand dislocation	Y		P2	1.4584	$61.16
26675	Treat hand dislocation	Y		A2	1.4584	$61.16
26676	Pin hand dislocation	Y		A2	24.5309	$1,028.80
26685	Treat hand dislocation	Y		A2	24.5309	$1,028.80
26686	Treat hand dislocation	Y		A2	61.8075	$2,592.14
26700	Treat knuckle dislocation	Y		P2	1.4584	$61.16
26705	Treat knuckle dislocation	Y		A2	1.4584	$61.16
26706	Pin knuckle dislocation	Y		A2	19.2479	$807.24

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
26715	Treat knuckle dislocation	Y		A2	24.5309	$1,028.80
26720	Treat finger fracture each	Y		P2	1.4584	$61.16
26725	Treat finger fracture each	Y		P2	1.4584	$61.16
26727	Treat finger fracture each	Y		A2	24.5309	$1,028.80
26735	Treat finger fracture each	Y		A2	24.5309	$1,028.80
26740	Treat finger fracture each	Y		P2	1.4584	$61.16
26742	Treat finger fracture each	Y		A2	1.4584	$61.16
26746	Treat finger fracture each	Y		A2	24.5309	$1,028.80
26750	Treat finger fracture each	Y		P2	1.4584	$61.16
26755	Treat finger fracture each	Y		G2	1.4584	$61.16
26756	Pin finger fracture each	Y		A2	24.5309	$1,028.80
26765	Treat finger fracture each	Y		A2	24.5309	$1,028.80
26770	Treat finger dislocation	Y		G2	1.4584	$61.16
26775	Treat finger dislocation	Y		P3		$157.98
26776	Pin finger dislocation	Y		A2	24.5309	$1,028.80
26785	Treat finger dislocation	Y		A2	24.5309	$1,028.80
26820	Thumb fusion with graft	Y		A2	27.5002	$1,153.33
26841	Fusion of thumb	Y		A2	27.5002	$1,153.33
26842	Thumb fusion with graft	Y		A2	27.5002	$1,153.33
26843	Fusion of hand joint	Y		A2	27.5002	$1,153.33
26844	Fusion/graft of hand joint	Y		A2	27.5002	$1,153.33
26850	Fusion of knuckle	Y		A2	27.5002	$1,153.33
26852	Fusion of knuckle with graft	Y		A2	27.5002	$1,153.33
26860	Fusion of finger joint	Y		A2	27.5002	$1,153.33
26861	Fusion of finger jnt add-on	Y		A2	27.5002	$1,153.33
26862	Fusion/graft of finger joint	Y		A2	27.5002	$1,153.33
26863	Fuse/graft added joint	Y		A2	27.5002	$1,153.33
26910	Amputate metacarpal bone	Y		A2	27.5002	$1,153.33
26951	Amputation of finger/thumb	Y		A2	15.8563	$665.00
26952	Amputation of finger/thumb	Y		A2	15.8563	$665.00
26990	Drainage of pelvis lesion	Y		A2	21.2238	$890.10
26991	Drainage of pelvis bursa	Y		A2	21.2238	$890.10
27000	Incision of hip tendon	Y		A2	21.2238	$890.10
27001	Incision of hip tendon	Y		A2	29.7869	$1,249.23
27003	Incision of hip tendon	Y		A2	29.7869	$1,249.23
27033	Exploration of hip joint	Y		A2	43.7154	$1,833.38

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
27035	Denervation of hip joint	Y		A2	43.7154	$1,833.38
27040	Biopsy of soft tissues	Y		A2	7.8457	$329.04
27041	Biopsy of soft tissues	Y		A2	7.8457	$329.04
27043	Exc hip pelvis les sc > 3 cm	Y		G2	22.0775	$925.91
27045	Exc hip/pelv tum deep > 5 cm	Y		G2	22.0775	$925.91
27047*	Exc hip/pelvis les sc < 3 cm	Y		P3		$209.28
27048	Exc hip/pelv tum deep < 5 cm	Y		G2	16.7008	$700.41
27049	Resect hip/pelv tum < 5 cm	Y		G2	16.7008	$700.41
27050	Biopsy of sacroiliac joint	Y		A2	21.2238	$890.10
27052	Biopsy of hip joint	Y		A2	21.2238	$890.10
27059	Resect hip/pelv tum > 5 cm	Y		G2	22.0775	$925.91
27060	Removal of ischial bursa	Y		A2	21.2238	$890.10
27062	Remove femur lesion/bursa	Y		A2	21.2238	$890.10
27065	Remove hip bone les super	Y		A2	21.2238	$890.10
27066	Remove hip bone les deep	Y		A2	29.7869	$1,249.23
27067	Remove/graft hip bone lesion	Y		A2	29.7869	$1,249.23
27080	Removal of tail bone	Y		A2	29.7869	$1,249.23
27086	Remove hip foreign body	Y		A2	7.8457	$329.04
27087	Remove hip foreign body	Y		A2	21.2238	$890.10
27093	Injection for hip x-ray	N		N1		
27095	Injection for hip x-ray	N		N1		
27097	Revision of hip tendon	Y		A2	29.7869	$1,249.23
27098	Transfer tendon to pelvis	Y		A2	29.7869	$1,249.23
27100	Transfer of abdominal muscle	Y		A2	43.7154	$1,833.38
27105	Transfer of spinal muscle	Y		A2	43.7154	$1,833.38
27110	Transfer of iliopsoas muscle	Y		A2	43.7154	$1,833.38
27111	Transfer of iliopsoas muscle	Y		A2	43.7154	$1,833.38
27193	Treat pelvic ring fracture	Y		A2	1.4584	$61.16
27194	Treat pelvic ring fracture	Y		A2	14.3662	$602.50
27200	Treat tail bone fracture	Y		P2	1.4584	$61.16
27202	Treat tail bone fracture	Y		A2	44.4642	$1,864.78
27220	Treat hip socket fracture	Y		G2	1.4584	$61.16
27230	Treat thigh fracture	Y		A2	1.4584	$61.16
27238	Treat thigh fracture	Y		A2	5.0855	$213.28
27246	Treat thigh fracture	Y		A2	5.0855	$213.28
27250	Treat hip dislocation	Y		A2	1.4584	$61.16

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
27252	Treat hip dislocation	Y		A2	14.3662	$602.50
27256	Treat hip dislocation	Y		G2	1.4584	$61.16
27257	Treat hip dislocation	Y		A2	14.3662	$602.50
27265	Treat hip dislocation	Y		A2	1.4584	$61.16
27266	Treat hip dislocation	Y		A2	14.3662	$602.50
27267	Clix thigh fx	Y		G2	1.4584	$61.16
27275	Manipulation of hip joint	Y		A2	14.3662	$602.50
27301	Drain thigh/knee lesion	Y		A2	18.6604	$782.60
27305	Incise thigh tendon & fascia	Y		A2	21.2238	$890.10
27306	Incision of thigh tendon	Y		A2	21.2238	$890.10
27307	Incision of thigh tendons	Y		A2	21.2238	$890.10
27310	Exploration of knee joint	Y		A2	29.7869	$1,249.23
27323	Biopsy thigh soft tissues	Y		A2	7.8457	$329.04
27324	Biopsy thigh soft tissues	Y		A2	22.0775	$925.91
27325	Neurectomy hamstring	Y		A2	17.6746	$741.26
27326	Neurectomy popliteal	Y		A2	17.6746	$741.26
27327*	Exc thigh/knee les sc < 3 cm	Y		P3		$203.15
27328	Exc thigh/knee tum deep <5cm	Y		G2	16.7008	$700.41
27329	Resect thigh/knee tum < 5 cm	Y		G2	16.7008	$700.41
27330	Biopsy knee joint lining	Y		A2	29.7869	$1,249.23
27331	Explore/treat knee joint	Y		A2	29.7869	$1,249.23
27332	Removal of knee cartilage	Y		A2	29.7869	$1,249.23
27333	Removal of knee cartilage	Y		A2	29.7869	$1,249.23
27334	Remove knee joint lining	Y		A2	29.7869	$1,249.23
27335	Remove knee joint lining	Y		A2	29.7869	$1,249.23
27337	Exc thigh/knee les sc 3+ cm	Y		G2	22.0775	$925.91
27339	Exc thigh/knee tum deep 5+cm	Y		G2	22.0775	$925.91
27340	Removal of kneecap bursa	Y		A2	21.2238	$890.10
27345	Removal of knee cyst	Y		A2	21.2238	$890.10
27347	Remove knee cyst	Y		A2	21.2238	$890.10
27350	Removal of kneecap	Y		A2	29.7869	$1,249.23
27355	Remove femur lesion	Y		A2	29.7869	$1,249.23
27356	Remove femur lesion/graft	Y		A2	29.7869	$1,249.23
27357	Remove femur lesion/graft	Y		A2	29.7869	$1,249.23
27358	Remove femur lesion/fixation	Y		A2	29.7869	$1,249.23

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
27360	Partial removal leg bone(s)	Y		A2	29.7869	$1,249.23
27364	Resect thigh/knee tum 5+ cm	Y		G2	22.0775	$925.91
27370	Injection for knee x-ray	N		N1		
27372	Removal of foreign body	Y		A2	22.0775	$925.91
27380	Repair of kneecap tendon	Y		A2	21.2238	$890.10
27381	Repair/graft kneecap tendon	Y		A2	21.2238	$890.10
27385	Repair of thigh muscle	Y		A2	21.2238	$890.10
27386	Repair/graft of thigh muscle	Y		A2	21.2238	$890.10
27390	Incision of thigh tendon	Y		A2	21.2238	$890.10
27391	Incision of thigh tendons	Y		A2	21.2238	$890.10
27392	Incision of thigh tendons	Y		A2	21.2238	$890.10
27393	Lengthening of thigh tendon	Y		A2	29.7869	$1,249.23
27394	Lengthening of thigh tendons	Y		A2	29.7869	$1,249.23
27395	Lengthening of thigh tendons	Y		A2	43.7154	$1,833.38
27396	Transplant of thigh tendon	Y		A2	29.7869	$1,249.23
27397	Transplants of thigh tendons	Y		A2	43.7154	$1,833.38
27400	Revise thigh muscles/tendons	Y		A2	43.7154	$1,833.38
27403	Repair of knee cartilage	Y		A2	29.7869	$1,249.23
27405	Repair of knee ligament	Y		A2	43.7154	$1,833.38
27407	Repair of knee ligament	Y		A2	82.2061	$3,447.64
27409	Repair of knee ligaments	Y		A2	82.2061	$3,447.64
27416	Osteochondral knee autograft	Y		G2	43.7154	$1,833.38
27418	Repair degenerated kneecap	Y		A2	43.7154	$1,833.38
27420	Revision of unstable kneecap	Y		A2	43.7154	$1,833.38
27422	Revision of unstable kneecap	Y		A2	43.7154	$1,833.38
27424	Revision/removal of kneecap	Y		A2	43.7154	$1,833.38
27425	Lat retinacular release open	Y		A2	29.7869	$1,249.23
27427	Reconstruction knee	Y		A2	82.2061	$3,447.64
27428	Reconstruction knee	Y		A2	82.2061	$3,447.64
27429	Reconstruction knee	Y		A2	82.2061	$3,447.64
27430	Revision of thigh muscles	Y		A2	43.7154	$1,833.38
27435	Incision of knee joint	Y		A2	43.7154	$1,833.38
27437	Revise kneecap	Y		A2	36.2919	$1,522.05
27438	Revise kneecap with implant	Y		A2	55.3881	$2,322.92
27440	Revision of knee joint	Y		G2	36.2919	$1,522.05
27441	Revision of knee joint	Y		A2	36.2919	$1,522.05

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
27442	Revision of knee joint	Y		A2	36.2919	$1,522.05
27443	Revision of knee joint	Y		A2	36.2919	$1,522.05
27446	Revision of knee joint	Y		J8	168.536	$7,068.23
27475	Surgery to stop leg growth	Y		G2	29.7869	$1,249.23
27479	Surgery to stop leg growth	Y		G2	29.7869	$1,249.23
27496	Decompression of thigh/knee	Y		A2	29.7869	$1,249.23
27497	Decompression of thigh/knee	Y		A2	21.2238	$890.10
27498	Decompression of thigh/knee	Y		A2	29.7869	$1,249.23
27499	Decompression of thigh/knee	Y		A2	29.7869	$1,249.23
27500	Treatment of thigh fracture	Y		A2	5.0855	$213.28
27501	Treatment of thigh fracture	Y		A2	1.4584	$61.16
27502	Treatment of thigh fracture	Y		A2	19.2479	$807.24
27503	Treatment of thigh fracture	Y		A2	1.4584	$61.16
27508	Treatment of thigh fracture	Y		A2	1.4584	$61.16
27509	Treatment of thigh fracture	Y		A2	24.5309	$1,028.80
27510	Treatment of thigh fracture	Y		A2	5.0855	$213.28
27516	Treat thigh fx growth plate	Y		A2	1.4584	$61.16
27517	Treat thigh fx growth plate	Y		A2	1.4584	$61.16
27520	Treat kneecap fracture	Y		A2	1.4584	$61.16
27530	Treat knee fracture	Y		A2	1.4584	$61.16
27532	Treat knee fracture	Y		A2	19.2479	$807.24
27538	Treat knee fracture(s)	Y		A2	1.4584	$61.16
27550	Treat knee dislocation	Y		A2	1.4584	$61.16
27552	Treat knee dislocation	Y		A2	14.3662	$602.50
27560	Treat kneecap dislocation	Y		A2	1.4584	$61.16
27562	Treat kneecap dislocation	Y		A2	14.3662	$602.50
27566	Treat kneecap dislocation	Y		A2	44.4642	$1,864.78
27570	Fixation of knee joint	Y		A2	14.3662	$602.50
27594	Amputation follow-up surgery	Y		A2	21.2238	$890.10
27600	Decompression of lower leg	Y		A2	21.2238	$890.10
27601	Decompression of lower leg	Y		A2	21.2238	$890.10
27602	Decompression of lower leg	Y		A2	21.2238	$890.10
27603	Drain lower leg lesion	Y		A2	18.6604	$782.60
27604	Drain lower leg bursa	Y		A2	21.2238	$890.10
27605	Incision of achilles tendon	Y		A2	20.8734	$875.41
27606	Incision of achilles tendon	Y		A2	21.2238	$890.10

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
27607	Treat lower leg bone lesion	Y		A2	21.2238	$890.10
27610	Explore/treat ankle joint	Y		A2	29.7869	$1,249.23
27612	Exploration of ankle joint	Y		A2	29.7869	$1,249.23
27613	Biopsy lower leg soft tissue	Y		P3		$121.74
27614	Biopsy lower leg soft tissue	Y		A2	22.0775	$925.91
27615	Resect leg/ankle tum < 5 cm	Y		G2	16.7008	$700.41
27616	Resect leg/ankle tum 5+ cm	Y		G2	22.0775	$925.91
27618*	Exc leg/ankle tum < 3 cm	Y		P3		$206.47
27619	Exc leg/ankle tum deep <5 cm	Y		G2	16.7008	$700.41
27620	Explore/treat ankle joint	Y		A2	29.7869	$1,249.23
27625	Remove ankle joint lining	Y		A2	29.7869	$1,249.23
27626	Remove ankle joint lining	Y		A2	29.7869	$1,249.23
27630	Removal of tendon lesion	Y		A2	21.2238	$890.10
27632	Exc leg/ankle les sc 3+ cm	Y		G2	22.0775	$925.91
27634	Exc leg/ankle tum deep 5+ cm	Y		G2	22.0775	$925.91
27635	Remove lower leg bone lesion	Y		A2	29.7869	$1,249.23
27637	Remove/graft leg bone lesion	Y		A2	29.7869	$1,249.23
27638	Remove/graft leg bone lesion	Y		A2	29.7869	$1,249.23
27640	Partial removal of tibia	Y		A2	43.7154	$1,833.38
27641	Partial removal of fibula	Y		A2	29.7869	$1,249.23
27647	Resect talus/calcaneus tum	Y		A2	43.7154	$1,833.38
27648	Injection for ankle x-ray	N		N1		
27650	Repair achilles tendon	Y		A2	43.7154	$1,833.38
27652	Repair/graft achilles tendon	Y		A2	82.2061	$3,447.64
27654	Repair of achilles tendon	Y		A2	43.7154	$1,833.38
27656	Repair leg fascia defect	Y		A2	21.2238	$890.10
27658	Repair of leg tendon each	Y		A2	21.2238	$890.10
27659	Repair of leg tendon each	Y		A2	21.2238	$890.10
27664	Repair of leg tendon each	Y		A2	29.7869	$1,249.23
27665	Repair of leg tendon each	Y		A2	29.7869	$1,249.23
27675	Repair lower leg tendons	Y		A2	21.2238	$890.10
27676	Repair lower leg tendons	Y		A2	29.7869	$1,249.23
27680	Release of lower leg tendon	Y		A2	29.7869	$1,249.23
27681	Release of lower leg tendons	Y		A2	29.7869	$1,249.23

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27685	Revision of lower leg tendon	Y		A2	29.7869	$1,249.23
27686	Revise lower leg tendons	Y		A2	29.7869	$1,249.23
27687	Revision of calf tendon	Y		A2	29.7869	$1,249.23
27690	Revise lower leg tendon	Y		A2	43.7154	$1,833.38
27691	Revise lower leg tendon	Y		A2	43.7154	$1,833.38
27692	Revise additional leg tendon	Y		A2	43.7154	$1,833.38
27695	Repair of ankle ligament	Y		A2	29.7869	$1,249.23
27696	Repair of ankle ligaments	Y		A2	29.7869	$1,249.23
27698	Repair of ankle ligament	Y		A2	29.7869	$1,249.23
27700	Revision of ankle joint	Y		A2	36.2919	$1,522.05
27704	Removal of ankle implant	Y		A2	21.2238	$890.10
27705	Incision of tibia	Y		A2	43.7154	$1,833.38
27707	Incision of fibula	Y		A2	21.2238	$890.10
27709	Incision of tibia & fibula	Y		A2	29.7869	$1,249.23
27720	Repair of tibia	Y		G2	44.4642	$1,864.78
27726	Repair fibula nonunion	Y		G2	44.4642	$1,864.78
27730	Repair of tibia epiphysis	Y		A2	29.7869	$1,249.23
27732	Repair of fibula epiphysis	Y		A2	29.7869	$1,249.23
27734	Repair lower leg epiphyses	Y		A2	29.7869	$1,249.23
27740	Repair of leg epiphyses	Y		A2	29.7869	$1,249.23
27742	Repair of leg epiphyses	Y		A2	43.7154	$1,833.38
27745	Reinforce tibia	Y		A2	82.2061	$3,447.64
27750	Treatment of tibia fracture	Y		A2	1.4584	$61.16
27752	Treatment of tibia fracture	Y		A2	19.2479	$807.24
27756	Treatment of tibia fracture	Y		A2	24.5309	$1,028.80
27758	Treatment of tibia fracture	Y		A2	44.4642	$1,864.78
27759	Treatment of tibia fracture	Y		A2	61.8075	$2,592.14
27760	Cltx medial ankle fx	Y		A2	1.4584	$61.16
27762	Cltx med ankle fx w/mnpj	Y		A2	19.2479	$807.24
27766	Optx medial ankle fx	Y		A2	44.4642	$1,864.78
27767	Cltx post ankle fx	Y	CH	P2	1.4584	$61.16
27768	Cltx post ankle fx w/mnpj	Y		G2	1.4584	$61.16
27769	Optx post ankle fx	Y		G2	44.4642	$1,864.78
27780	Treatment of fibula fracture	Y		A2	1.4584	$61.16
27781	Treatment of fibula fracture	Y		A2	19.2479	$807.24
27784	Treatment of fibula fracture	Y		A2	44.4642	$1,864.78

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27786	Treatment of ankle fracture	Y		A2	1.4584	$61.16
27788	Treatment of ankle fracture	Y		A2	1.4584	$61.16
27792	Treatment of ankle fracture	Y		A2	44.4642	$1,864.78
27808	Treatment of ankle fracture	Y		A2	1.4584	$61.16
27810	Treatment of ankle fracture	Y		A2	1.4584	$61.16
27814	Treatment of ankle fracture	Y		A2	44.4642	$1,864.78
27816	Treatment of ankle fracture	Y		A2	1.4584	$61.16
27818	Treatment of ankle fracture	Y		A2	5.0855	$213.28
27822	Treatment of ankle fracture	Y		A2	44.4642	$1,864.78
27823	Treatment of ankle fracture	Y		A2	61.8075	$2,592.14
27824	Treat lower leg fracture	Y		A2	1.4584	$61.16
27825	Treat lower leg fracture	Y		A2	19.2479	$807.24
27826	Treat lower leg fracture	Y		A2	44.4642	$1,864.78
27827	Treat lower leg fracture	Y		A2	61.8075	$2,592.14
27828	Treat lower leg fracture	Y		A2	61.8075	$2,592.14
27829	Treat lower leg joint	Y		A2	44.4642	$1,864.78
27830	Treat lower leg dislocation	Y		A2	1.4584	$61.16
27831	Treat lower leg dislocation	Y		A2	19.2479	$807.24
27832	Treat lower leg dislocation	Y		A2	44.4642	$1,864.78
27840	Treat ankle dislocation	Y		A2	1.4584	$61.16
27842	Treat ankle dislocation	Y		A2	14.3662	$602.50
27846	Treat ankle dislocation	Y		A2	44.4642	$1,864.78
27848	Treat ankle dislocation	Y		A2	44.4642	$1,864.78
27860	Fixation of ankle joint	Y		A2	14.3662	$602.50
27870	Fusion of ankle joint open	Y		A2	82.2061	$3,447.64
27871	Fusion of tibiofibular joint	Y		A2	82.2061	$3,447.64
27884	Amputation follow-up surgery	Y		A2	21.2238	$890.10
27889	Amputation of foot at ankle	Y		A2	29.7869	$1,249.23
27892	Decompression of leg	Y		A2	29.7869	$1,249.23
27893	Decompression of leg	Y		A2	29.7869	$1,249.23
27894	Decompression of leg	Y		A2	29.7869	$1,249.23
28001	Drainage of bursa of foot	Y		P3		$121.48
28002	Treatment of foot infection	Y		A2	21.2238	$890.10
28003	Treatment of foot infection	Y		A2	21.2238	$890.10
28005	Treat foot bone lesion	Y		A2	20.8734	$875.41
28008	Incision of foot fascia	Y		A2	20.8734	$875.41

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
28010	Incision of toe tendon	Y		P3		$88.82
28011	Incision of toe tendons	Y		A2	20.8734	$875.41
28020	Exploration of foot joint	Y		A2	20.8734	$875.41
28022	Exploration of foot joint	Y		A2	20.8734	$875.41
28024	Exploration of toe joint	Y		A2	20.8734	$875.41
28035	Decompression of tibia nerve	Y		A2	17.6746	$741.26
28039*	Exc foot/toe tum sc > 1.5 cm	Y		P3		$214.38
28041*	Exc foot/toe tum deep 1.5cm+	Y		R2	22.0775	$925.91
28043*	Exc foot/toe tum sc < 1.5 cm	Y		P3		$166.66
28045*	Exc foot/toe tum deep <1.5cm	Y		P3		$215.91
28046*	Resect foot/toe tumor < 3 cm	Y		R2	16.7008	$700.41
28047	Resect foot/toe tumor > 3 cm	Y		G2	22.0775	$925.91
28050	Biopsy of foot joint lining	Y		A2	20.8734	$875.41
28052	Biopsy of foot joint lining	Y		A2	20.8734	$875.41
28054	Biopsy of toe joint lining	Y		A2	20.8734	$875.41
28055	Neurectomy foot	Y		A2	17.6746	$741.26
28060	Partial removal foot fascia	Y		A2	20.8734	$875.41
28062	Removal of foot fascia	Y		A2	20.8734	$875.41
28070	Removal of foot joint lining	Y		A2	20.8734	$875.41
28072	Removal of foot joint lining	Y		A2	20.8734	$875.41
28080	Removal of foot lesion	Y		A2	20.8734	$875.41
28086	Excise foot tendon sheath	Y		A2	20.8734	$875.41
28088	Excise foot tendon sheath	Y		A2	20.8734	$875.41
28090	Removal of foot lesion	Y		A2	20.8734	$875.41
28092	Removal of toe lesions	Y		A2	20.8734	$875.41
28100	Removal of ankle/heel lesion	Y		A2	20.8734	$875.41
28102	Remove/graft foot lesion	Y		A2	51.0472	$2,140.87
28103	Remove/graft foot lesion	Y		A2	51.0472	$2,140.87
28104	Removal of foot lesion	Y		A2	20.8734	$875.41
28106	Remove/graft foot lesion	Y		A2	51.0472	$2,140.87
28107	Remove/graft foot lesion	Y		A2	51.0472	$2,140.87
28108	Removal of toe lesions	Y		A2	20.8734	$875.41
28110	Part removal of metatarsal	Y		A2	20.8734	$875.41
28111	Part removal of metatarsal	Y		A2	20.8734	$875.41
28112	Part removal of metatarsal	Y		A2	20.8734	$875.41
28113	Part removal of metatarsal	Y		A2	20.8734	$875.41

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28114	Removal of metatarsal heads	Y		A2	20.8734	$875.41
28116	Revision of foot	Y		A2	20.8734	$875.41
28118	Removal of heel bone	Y		A2	20.8734	$875.41
28119	Removal of heel spur	Y		A2	20.8734	$875.41
28120	Part removal of ankle/heel	Y		A2	20.8734	$875.41
28122	Partial removal of foot bone	Y		A2	20.8734	$875.41
28124	Partial removal of toe	Y		P3		$206.73
28126	Partial removal of toe	Y		A2	20.8734	$875.41
28130	Removal of ankle bone	Y		A2	20.8734	$875.41
28140	Removal of metatarsal	Y		A2	20.8734	$875.41
28150	Removal of toe	Y		A2	20.8734	$875.41
28153	Partial removal of toe	Y		A2	20.8734	$875.41
28160	Partial removal of toe	Y		A2	20.8734	$875.41
28171	Resect tarsal tumor	Y		A2	20.8734	$875.41
28173	Resect metatarsal tumor	Y		A2	20.8734	$875.41
28175	Resect phalanx of toe tumor	Y		A2	20.8734	$875.41
28190	Removal of foot foreign body	Y		P3		$126.33
28192	Removal of foot foreign body	Y		A2	16.7008	$700.41
28193	Removal of foot foreign body	Y		A2	7.8457	$329.04
28200	Repair of foot tendon	Y		A2	20.8734	$875.41
28202	Repair/graft of foot tendon	Y		A2	20.8734	$875.41
28208	Repair of foot tendon	Y		A2	20.8734	$875.41
28210	Repair/graft of foot tendon	Y		A2	51.0472	$2,140.87
28220	Release of foot tendon	Y		P3		$194.99
28222	Release of foot tendons	Y		A2	20.8734	$875.41
28225	Release of foot tendon	Y		A2	20.8734	$875.41
28226	Release of foot tendons	Y		A2	20.8734	$875.41
28230	Incision of foot tendon(s)	Y		P3		$190.90
28232	Incision of toe tendon	Y		P3		$183.50
28234	Incision of foot tendon	Y		A2	20.8734	$875.41
28238	Revision of foot tendon	Y		A2	51.0472	$2,140.87
28240	Release of big toe	Y		A2	20.8734	$875.41
28250	Revision of foot fascia	Y		A2	20.8734	$875.41
28260	Release of midfoot joint	Y		A2	20.8734	$875.41
28261	Revision of foot tendon	Y		A2	20.8734	$875.41
28262	Revision of foot and ankle	Y		A2	20.8734	$875.41

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28264	Release of midfoot joint	Y		A2	51.0472	$2,140.87
28270	Release of foot contracture	Y		A2	20.8734	$875.41
28272	Release of toe joint each	Y		P3		$176.35
28280	Fusion of toes	Y		A2	20.8734	$875.41
28285	Repair of hammertoe	Y		A2	20.8734	$875.41
28286	Repair of hammertoe	Y		A2	20.8734	$875.41
28288	Partial removal of foot bone	Y		A2	20.8734	$875.41
28289	Repair hallux rigidus	Y		A2	20.8734	$875.41
28290	Correction of bunion	Y		A2	30.7115	$1,288.01
28292	Correction of bunion	Y		A2	30.7115	$1,288.01
28293	Correction of bunion	Y		A2	30.7115	$1,288.01
28294	Correction of bunion	Y		A2	30.7115	$1,288.01
28296	Correction of bunion	Y		A2	30.7115	$1,288.01
28297	Correction of bunion	Y		A2	30.7115	$1,288.01
28298	Correction of bunion	Y		A2	30.7115	$1,288.01
28299	Correction of bunion	Y		A2	30.7115	$1,288.01
28300	Incision of heel bone	Y		A2	51.0472	$2,140.87
28302	Incision of ankle bone	Y		A2	20.8734	$875.41
28304	Incision of midfoot bones	Y		A2	51.0472	$2,140.87
28305	Incise/graft midfoot bones	Y		A2	51.0472	$2,140.87
28306	Incision of metatarsal	Y		A2	20.8734	$875.41
28307	Incision of metatarsal	Y		A2	20.8734	$875.41
28308	Incision of metatarsal	Y		A2	20.8734	$875.41
28309	Incision of metatarsals	Y		A2	51.0472	$2,140.87
28310	Revision of big toe	Y		A2	20.8734	$875.41
28312	Revision of toe	Y		A2	20.8734	$875.41
28313	Repair deformity of toe	Y		A2	20.8734	$875.41
28315	Removal of sesamoid bone	Y		A2	20.8734	$875.41
28320	Repair of foot bones	Y		A2	51.0472	$2,140.87
28322	Repair of metatarsals	Y		A2	51.0472	$2,140.87
28340	Resect enlarged toe tissue	Y		A2	20.8734	$875.41
28341	Resect enlarged toe	Y		A2	20.8734	$875.41
28344	Repair extra toe(s)	Y		A2	20.8734	$875.41
28345	Repair webbed toe(s)	Y		A2	20.8734	$875.41
28400	Treatment of heel fracture	Y		A2	1.4584	$61.16
28405	Treatment of heel fracture	Y		A2	19.2479	$807.24

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
28406	Treatment of heel fracture	Y		A2	24.5309	$1,028.80
28415	Treat heel fracture	Y		A2	61.8075	$2,592.14
28420	Treat/graft heel fracture	Y		A2	44.4642	$1,864.78
28430	Treatment of ankle fracture	Y		P2	1.4584	$61.16
28435	Treatment of ankle fracture	Y		A2	1.4584	$61.16
28436	Treatment of ankle fracture	Y		A2	24.5309	$1,028.80
28445	Treat ankle fracture	Y		A2	44.4642	$1,864.78
28446	Osteochondral talus autogrft	Y		G2	51.0472	$2,140.87
28450	Treat midfoot fracture each	Y		P2	1.4584	$61.16
28455	Treat midfoot fracture each	Y		P2	1.4584	$61.16
28456	Treat midfoot fracture	Y		A2	24.5309	$1,028.80
28465	Treat midfoot fracture each	Y		A2	44.4642	$1,864.78
28470	Treat metatarsal fracture	Y		P2	1.4584	$61.16
28475	Treat metatarsal fracture	Y		P2	1.4584	$61.16
28476	Treat metatarsal fracture	Y		A2	24.5309	$1,028.80
28485	Treat metatarsal fracture	Y		A2	44.4642	$1,864.78
28490	Treat big toe fracture	Y		P2	1.4584	$61.16
28495	Treat big toe fracture	Y		P2	1.4584	$61.16
28496	Treat big toe fracture	Y		A2	24.5309	$1,028.80
28505	Treat big toe fracture	Y		A2	24.5309	$1,028.80
28510	Treatment of toe fracture	Y		P3		$54.11
28515	Treatment of toe fracture	Y		P2	1.4584	$61.16
28525	Treat toe fracture	Y		A2	24.5309	$1,028.80
28530	Treat sesamoid bone fracture	Y		P3		$52.32
28531	Treat sesamoid bone fracture	Y		A2	24.5309	$1,028.80
28540	Treat foot dislocation	Y		P2	1.4584	$61.16
28545	Treat foot dislocation	Y		A2	24.5309	$1,028.80
28546	Treat foot dislocation	Y		A2	24.5309	$1,028.80
28555	Repair foot dislocation	Y		A2	44.4642	$1,864.78
28570	Treat foot dislocation	Y		P2	1.4584	$61.16
28575	Treat foot dislocation	Y		A2	19.2479	$807.24
28576	Treat foot dislocation	Y		A2	24.5309	$1,028.80
28585	Repair foot dislocation	Y		A2	24.5309	$1,028.80
28600	Treat foot dislocation	Y		P2	1.4584	$61.16
28605	Treat foot dislocation	Y		A2	1.4584	$61.16
28606	Treat foot dislocation	Y		A2	24.5309	$1,028.80

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28615	Repair foot dislocation	Y		A2	44.4642	$1,864.78
28630	Treat toe dislocation	Y		P3		$59.98
28635	Treat toe dislocation	Y		A2	14.3662	$602.50
28636	Treat toe dislocation	Y		A2	24.5309	$1,028.80
28645	Repair toe dislocation	Y		A2	24.5309	$1,028.80
28660	Treat toe dislocation	Y		P3		$43.64
28665	Treat toe dislocation	Y		A2	14.3662	$602.50
28666	Treat toe dislocation	Y		A2	24.5309	$1,028.80
28675	Repair of toe dislocation	Y		A2	24.5309	$1,028.80
28705	Fusion of foot bones	Y		A2	51.0472	$2,140.87
28715	Fusion of foot bones	Y		A2	82.2061	$3,447.64
28725	Fusion of foot bones	Y		A2	51.0472	$2,140.87
28730	Fusion of foot bones	Y		A2	51.0472	$2,140.87
28735	Fusion of foot bones	Y		A2	51.0472	$2,140.87
28737	Revision of foot bones	Y		A2	51.0472	$2,140.87
28740	Fusion of foot bones	Y		A2	51.0472	$2,140.87
28750	Fusion of big toe joint	Y		A2	51.0472	$2,140.87
28755	Fusion of big toe joint	Y		A2	20.8734	$875.41
28760	Fusion of big toe joint	Y		A2	51.0472	$2,140.87
28810	Amputation toe & metatarsal	Y		A2	20.8734	$875.41
28820	Amputation of toe	Y		A2	20.8734	$875.41
28825	Partial amputation of toe	Y		A2	20.8734	$875.41
28890	High energy eswt plantar f	Y		P3		$154.92
29000	Application of body cast	N		G2	1.0347	$43.39
29010	Application of body cast	N		P2	2.3525	$98.66
29015	Application of body cast	N		P2	2.3525	$98.66
29020	Application of body cast	N		G2	1.0347	$43.39
29025	Application of body cast	N		P2	1.0347	$43.39
29035	Application of body cast	N		P2	2.3525	$98.66
29040	Application of body cast	N		G2	1.0347	$43.39
29044	Application of body cast	N		P2	2.3525	$98.66
29046	Application of body cast	N		G2	2.3525	$98.66
29049	Application of figure eight	N		P3		$40.58
29055	Application of shoulder cast	N		P2	2.3525	$98.66
29058	Application of shoulder cast	N		P3		$35.48
29065	Application of long arm cast	N		P3		$42.62

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29075	Application of forearm cast	N		P3		$41.09
29085	Apply hand/wrist cast	N		P3		$42.37
29086	Apply finger cast	N		P3		$36.24
29105	Apply long arm splint	N		P3		$36.75
29125	Apply forearm splint	N		P3		$32.16
29126	Apply forearm splint	N		P3		$34.45
29130	Application of finger splint	N		P3		$14.80
29131	Application of finger splint	N		P3		$21.44
29200	Strapping of chest	N		P3		$20.67
29240	Strapping of shoulder	N		P3		$22.20
29260	Strapping of elbow or wrist	N		P3		$21.95
29280	Strapping of hand or finger	N		P3		$22.46
29305	Application of hip cast	N		P2	2.3525	$98.66
29325	Application of hip casts	N		P2	2.3525	$98.66
29345	Application of long leg cast	N		P3		$55.89
29355	Application of long leg cast	N		P3		$55.89
29358	Apply long leg cast brace	N		P3		$70.18
29365	Application of long leg cast	N		P3		$53.09
29405	Apply short leg cast	N		P3		$39.30
29425	Apply short leg cast	N		P3		$39.81
29435	Apply short leg cast	N		P3		$50.28
29440	Addition of walker to cast	N		P3		$18.63
29445	Apply rigid leg cast	N		P3		$51.81
29450	Application of leg cast	N		P2	1.0347	$43.39
29505	Application long leg splint	N		P3		$35.73
29515	Application lower leg splint	N		P3		$31.14
29520	Strapping of hip	N		P3		$21.44
29530	Strapping of knee	N		P3		$21.95
29540	Strapping of ankle and/or ft	N		P3		$15.82
29550	Strapping of toes	N		P3		$15.82
29580	Application of paste boot	N		P3		$22.71
29581	Apply multlay comprs lwr leg	N		P2	1.0347	$43.39
29590	Application of foot splint	N		P3		$18.12
29700	Removal/revision of cast	N		P3		$30.63
29705	Removal/revision of cast	N		P3		$26.03
29710	Removal/revision of cast	N		P3		$47.73

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29715	Removal/revision of cast	N		P3		$35.22
29720	Repair of body cast	N		P3		$38.79
29730	Windowing of cast	N		P3		$25.01
29740	Wedging of cast	N		P3		$32.92
29750	Wedging of clubfoot cast	N		P3		$35.99
29800	Jaw arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29804	Jaw arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29805	Shoulder arthroscopy dx	Y		A2	27.6837	$1,161.03
29806	Shoulder arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29807	Shoulder arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29819	Shoulder arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29820	Shoulder arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29821	Shoulder arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29822	Shoulder arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29823	Shoulder arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29824	Shoulder arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29825	Shoulder arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29826	Shoulder arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29827	Arthroscop rotator cuff repr	Y		A2	44.7515	$1,876.83
29828	Arthroscopy biceps tenodesis	Y		G2	44.7515	$1,876.83
29830	Elbow arthroscopy	Y		A2	27.6837	$1,161.03
29834	Elbow arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29835	Elbow arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29836	Elbow arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29837	Elbow arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29838	Elbow arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29840	Wrist arthroscopy	Y		A2	27.6837	$1,161.03
29843	Wrist arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29844	Wrist arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29845	Wrist arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29846	Wrist arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29847	Wrist arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29848	Wrist endoscopy/surgery	Y		A2	27.6837	$1,161.03
29850	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29851	Knee arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29855	Tibial arthroscopy/surgery	Y		A2	44.7515	$1,876.83

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29856	Tibial arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29860	Hip arthroscopy dx	Y		A2	44.7515	$1,876.83
29861	Hip arthro w/fb removal	Y		A2	44.7515	$1,876.83
29862	Hip arthr0 w/debridement	Y		A2	44.7515	$1,876.83
29863	Hip arthr0 w/synovectomy	Y		A2	44.7515	$1,876.83
29866	Autgrft implnt knee w/scope	Y		G2	44.7515	$1,876.83
29870	Knee arthroscopy dx	Y		A2	27.6837	$1,161.03
29871	Knee arthroscopy/drainage	Y		A2	27.6837	$1,161.03
29873	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29874	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29875	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29876	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29877	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29879	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29880	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29881	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29882	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29883	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29884	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29885	Knee arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29886	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29887	Knee arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29888	Knee arthroscopy/surgery	Y		A2	82.2061	$3,447.64
29889	Knee arthroscopy/surgery	Y		A2	82.2061	$3,447.64
29891	Ankle arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29892	Ankle arthroscopy/surgery	Y		A2	82.2061	$3,447.64
29893	Scope plantar fasciotomy	Y		A2	20.8734	$875.41
29894	Ankle arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29895	Ankle arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29897	Ankle arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29898	Ankle arthroscopy/surgery	Y		A2	27.6837	$1,161.03
29899	Ankle arthroscopy/surgery	Y		A2	44.7515	$1,876.83
29900	Mcp joint arthroscopy dx	Y		A2	27.6837	$1,161.03
29901	Mcp joint arthroscopy surg	Y		A2	27.6837	$1,161.03
29902	Mcp joint arthroscopy surg	Y		A2	27.6837	$1,161.03
29904	Subtalar arthro w/fb rmvl	Y		G2	27.6837	$1,161.03

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29905	Subtalar arthro w/exc	Y		G2	27.6837	$1,161.03
29906	Subtalar arthro w/deb	Y		G2	27.6837	$1,161.03
29907	Subtalar arthro w/fusion	Y		G2	44.7515	$1,876.83
29914	Hip arthro w/femoroplasty	Y	NI	G2	44.7515	$1,876.83
29915	Hip arthro acetabuloplasty	Y	NI	G2	44.7515	$1,876.83
29916	Hip arthro w/labral repair	Y	NI	G2	44.7515	$1,876.83
30000	Drainage of nose lesion	Y		P3		$129.40
30020	Drainage of nose lesion	Y		P3		$128.12
30100	Intranasal biopsy	Y		P3		$78.35
30110	Removal of nose polyp(s)	Y		P3		$122.25
30115	Removal of nose polyp(s)	Y		A2	16.0176	$671.76
30117	Removal of intranasal lesion	Y		A2	16.0176	$671.76
30118	Removal of intranasal lesion	Y		A2	23.6929	$993.66
30120	Revision of nose	Y		A2	23.6929	$993.66
30124	Removal of nose lesion	Y		R2	7.3159	$306.82
30125	Removal of nose lesion	Y		A2	41.2845	$1,731.43
30130	Excise inferior turbinate	Y		A2	16.0176	$671.76
30140	Resect inferior turbinate	Y		A2	23.6929	$993.66
30150	Partial removal of nose	Y		A2	41.2845	$1,731.43
30160	Removal of nose	Y		A2	41.2845	$1,731.43
30200	Injection treatment of nose	Y		P3		$62.02
30210	Nasal sinus therapy	Y		P3		$78.86
30220	Insert nasal septal button	Y		A2	7.3159	$306.82
30300	Remove nasal foreign body	N		P2	0.6201	$26.01
30310	Remove nasal foreign body	Y		A2	16.0176	$671.76
30320	Remove nasal foreign body	Y		A2	16.0176	$671.76
30400	Reconstruction of nose	Y		A2	41.2845	$1,731.43
30410	Reconstruction of nose	Y		A2	41.2845	$1,731.43
30420	Reconstruction of nose	Y		A2	41.2845	$1,731.43
30430	Revision of nose	Y		A2	23.6929	$993.66
30435	Revision of nose	Y		A2	41.2845	$1,731.43
30450	Revision of nose	Y		A2	41.2845	$1,731.43
30460	Revision of nose	Y		A2	41.2845	$1,731.43
30462	Revision of nose	Y		A2	41.2845	$1,731.43
30465	Repair nasal stenosis	Y		A2	41.2845	$1,731.43
30520	Repair of nasal septum	Y		A2	23.6929	$993.66

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30540	Repair nasal defect	Y		A2	41.2845	$1,731.43
30545	Repair nasal defect	Y		A2	41.2845	$1,731.43
30560	Release of nasal adhesions	Y		A2	3.283	$137.69
30580	Repair upper jaw fistula	Y		A2	41.2845	$1,731.43
30600	Repair mouth/nose fistula	Y		A2	41.2845	$1,731.43
30620	Intranasal reconstruction	Y		A2	41.2845	$1,731.43
30630	Repair nasal septum defect	Y		A2	23.6929	$993.66
30801	Ablate inf turbinate superf	Y		A2	7.3159	$306.82
30802	Ablate inf turbinate submuc	Y		A2	16.0176	$671.76
30901	Control of nosebleed	Y		P3		$40.07
30903	Control of nosebleed	Y		A2	1.0468	$43.90
30905	Control of nosebleed	Y		A2	1.0468	$43.90
30906	Repeat control of nosebleed	Y		A2	1.0468	$43.90
30915	Ligation nasal sinus artery	Y		A2	25.3611	$1,063.62
30920	Ligation upper jaw artery	Y		A2	25.3611	$1,063.62
30930	Ther fx nasal inf turbinate	Y		A2	16.0176	$671.76
31000	Irrigation maxillary sinus	Y		P3		$100.30
31002	Irrigation sphenoid sinus	Y		R2	7.3159	$306.82
31020	Exploration maxillary sinus	Y		A2	23.6929	$993.66
31030	Exploration maxillary sinus	Y		A2	41.2845	$1,731.43
31032	Explore sinus remove polyps	Y		A2	41.2845	$1,731.43
31040	Exploration behind upper jaw	Y		R2	23.6929	$993.66
31050	Exploration sphenoid sinus	Y		A2	41.2845	$1,731.43
31051	Sphenoid sinus surgery	Y		A2	41.2845	$1,731.43
31070	Exploration of frontal sinus	Y		A2	23.6929	$993.66
31075	Exploration of frontal sinus	Y		A2	41.2845	$1,731.43
31080	Removal of frontal sinus	Y		A2	41.2845	$1,731.43
31081	Removal of frontal sinus	Y		A2	41.2845	$1,731.43
31084	Removal of frontal sinus	Y		A2	41.2845	$1,731.43
31085	Removal of frontal sinus	Y		A2	41.2845	$1,731.43
31086	Removal of frontal sinus	Y		A2	41.2845	$1,731.43
31087	Removal of frontal sinus	Y		A2	41.2845	$1,731.43
31090	Exploration of sinuses	Y		A2	41.2845	$1,731.43
31200	Removal of ethmoid sinus	Y		A2	41.2845	$1,731.43
31201	Removal of ethmoid sinus	Y		A2	41.2845	$1,731.43
31205	Removal of ethmoid sinus	Y		A2	41.2845	$1,731.43

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
31231	Nasal endoscopy dx	Y		P2	1.8581	$77.93
31233	Nasal/sinus endoscopy dx	Y		A2	1.8581	$77.93
31235	Nasal/sinus endoscopy dx	Y		A2	20.2726	$850.21
31237	Nasal/sinus endoscopy surg	Y		A2	20.2726	$850.21
31238	Nasal/sinus endoscopy surg	Y		A2	20.2726	$850.21
31239	Nasal/sinus endoscopy surg	Y		A2	28.5882	$1,198.96
31240	Nasal/sinus endoscopy surg	Y		A2	20.2726	$850.21
31254	Revision of ethmoid sinus	Y		A2	28.5882	$1,198.96
31255	Removal of ethmoid sinus	Y		A2	28.5882	$1,198.96
31256	Exploration maxillary sinus	Y		A2	28.5882	$1,198.96
31267	Endoscopy maxillary sinus	Y		A2	28.5882	$1,198.96
31276	Sinus endoscopy surgical	Y		A2	28.5882	$1,198.96
31287	Nasal/sinus endoscopy surg	Y		A2	28.5882	$1,198.96
31288	Nasal/sinus endoscopy surg	Y		A2	28.5882	$1,198.96
31295	Sinus endo w/balloon dil	Y	NI	G2	28.5882	$1,198.96
31296	Sinus endo w/balloon dil	Y	NI	G2	28.5882	$1,198.96
31297	Sinus endo w/balloon dil	Y	NI	G2	28.5882	$1,198.96
31300	Removal of larynx lesion	Y		A2	23.6929	$993.66
31320	Diagnostic incision larynx	Y		A2	41.2845	$1,731.43
31400	Revision of larynx	Y		A2	41.2845	$1,731.43
31420	Removal of epiglottis	Y		A2	41.2845	$1,731.43
31500	Insert emergency airway	N		G2	2.1867	$91.71
31502	Change of windpipe airway	N		G2	1.3227	$55.47
31505	Diagnostic laryngoscopy	Y		P2	0.8589	$36.02
31510	Laryngoscopy with biopsy	Y		A2	20.2726	$850.21
31511	Remove foreign body larynx	Y		A2	1.8581	$77.93
31512	Removal of larynx lesion	Y		A2	20.2726	$850.21
31513	Injection into vocal cord	Y		A2	1.8581	$77.93
31515	Laryngoscopy for aspiration	Y		A2	20.2726	$850.21
31520	Dx laryngoscopy newborn	Y		G2	1.8581	$77.93
31525	Dx laryngoscopy excl nb	Y		A2	20.2726	$850.21
31526	Dx laryngoscopy w/oper scope	Y		A2	20.2726	$850.21
31527	Laryngoscopy for treatment	Y		A2	28.5882	$1,198.96
31528	Laryngoscopy and dilation	Y		A2	20.2726	$850.21
31529	Laryngoscopy and dilation	Y		A2	20.2726	$850.21
31530	Laryngoscopy w/fb removal	Y		A2	20.2726	$850.21

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
31531	Laryngoscopy w/fb & op scope	Y		A2	20.2726	$850.21
31535	Laryngoscopy w/biopsy	Y		A2	20.2726	$850.21
31536	Laryngoscopy w/bx & op scope	Y		A2	20.2726	$850.21
31540	Laryngoscopy w/exc of tumor	Y		A2	20.2726	$850.21
31541	Larynscop w/tumr exc + scope	Y		A2	20.2726	$850.21
31545	Remove vc lesion w/scope	Y		A2	28.5882	$1,198.96
31546	Remove vc lesion scope/graft	Y		A2	28.5882	$1,198.96
31560	Laryngoscop w/arytenoidectom	Y		A2	28.5882	$1,198.96
31561	Larynscop remve cart + scop	Y		A2	28.5882	$1,198.96
31570	Laryngoscope w/vc inj	Y		A2	20.2726	$850.21
31571	Laryngoscop w/vc inj + scope	Y		A2	28.5882	$1,198.96
31575	Diagnostic laryngoscopy	Y		P3		$55.64
31576	Laryngoscopy with biopsy	Y		A2	20.2726	$850.21
31577	Remove foreign body larynx	Y		A2	3.9031	$163.69
31578	Removal of larynx lesion	Y		A2	28.5882	$1,198.96
31579	Diagnostic laryngoscopy	Y		P3		$97.75
31580	Revision of larynx	Y		A2	41.2845	$1,731.43
31582	Revision of larynx	Y		A2	41.2845	$1,731.43
31588	Revision of larynx	Y		A2	41.2845	$1,731.43
31590	Reinnervate larynx	Y		A2	41.2845	$1,731.43
31595	Larynx nerve surgery	Y		A2	41.2845	$1,731.43
31603	Incision of windpipe	Y		A2	7.3159	$306.82
31605	Incision of windpipe	Y		G2	7.3159	$306.82
31611	Surgery/speech prosthesis	Y		A2	23.6929	$993.66
31612	Puncture/clear windpipe	Y		A2	23.6929	$993.66
31613	Repair windpipe opening	Y		A2	23.6929	$993.66
31614	Repair windpipe opening	Y		A2	41.2845	$1,731.43
31615	Visualization of windpipe	Y		A2	7.3159	$306.82
31620	Endobronchial us add-on	N		N1		
31622	Dx bronchoscope/wash	Y		A2	9.7005	$406.83
31623	Dx bronchoscope/brush	Y		A2	9.7005	$406.83
31624	Dx bronchoscope/lavage	Y		A2	9.7005	$406.83
31625	Bronchoscopy w/biopsy(s)	Y		A2	9.7005	$406.83

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31626	Bronchoscopy w/markers	Y		G2	9.7005	$406.83
31627	Navigational bronchoscopy	N		N1		
31628	Bronchoscopy/lung bx each	Y		A2	9.7005	$406.83
31629	Bronchoscopy/needle bx each	Y		A2	9.7005	$406.83
31630	Bronchoscopy dilate/fx repr	Y		A2	26.4464	$1,109.14
31631	Bronchoscopy dilate w/stent	Y		A2	26.4464	$1,109.14
31632	Bronchoscopy/lung bx addl	Y		G2	9.7005	$406.83
31633	Bronchoscopy/needle bx addl	Y		G2	9.7005	$406.83
31634	Bronch w/balloon occlusion	Y	NI	G2	9.7005	$406.83
31635	Bronchoscopy w/fb removal	Y		A2	9.7005	$406.83
31636	Bronchoscopy bronch stents	Y		A2	26.4464	$1,109.14
31637	Bronchoscopy stent add-on	Y		A2	9.7005	$406.83
31638	Bronchoscopy revise stent	Y		A2	26.4464	$1,109.14
31640	Bronchoscopy w/tumor excise	Y		A2	26.4464	$1,109.14
31641	Bronchoscopy treat blockage	Y		A2	26.4464	$1,109.14
31643	Diag bronchoscope/catheter	Y		A2	9.7005	$406.83
31645	Bronchoscopy clear airways	Y		A2	9.7005	$406.83
31646	Bronchoscopy reclear airway	Y		A2	9.7005	$406.83
31656	Bronchoscopy inj for x-ray	Y		A2	9.7005	$406.83
31715	injection for bronchus x-ray	N		N1		
31717	Bronchial brush biopsy	Y		A2	3.9031	$163.69
31720	Clearance of airways	N		A2	0.3853	$16.16
31730	Intro windpipe wire/tube	Y		A2	3.9031	$163.69
31750	Repair of windpipe	Y		A2	41.2845	$1,731.43
31755	Repair of windpipe	Y		A2	41.2845	$1,731.43
31820	Closure of windpipe lesion	Y		A2	23.6929	$993.66
31825	Repair of windpipe defect	Y		A2	23.6929	$993.66
31830	Revise windpipe scar	Y		A2	23.6929	$993.66
32400	Needle biopsy chest lining	Y		A2	8.9935	$377.18
32405	Biopsy lung or mediastinum	Y		A2	8.9935	$377.18
32420	Puncture/clear lung	Y		A2	5.1392	$215.53
32421	Thoracentesis for aspiration	Y		A2	5.1392	$215.53
32422	Thoracentesis w/tube insert	Y		G2	5.1392	$215.53
32550	Insert pleural cath	Y		G2	28.6387	$1,201.08
32552	Remove lung catheter	N		G2	1.3227	$55.47
32553	Ins mark thor for rt perq	N		G2	12.4299	$521.30

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32960	Therapeutic pneumothorax	Y		G2	5.1392	$215.53
32998	Perq rf ablate tx pul tumor	Y		G2	52.256	$2,191.56
33010	Drainage of heart sac	Y		A2	5.1392	$215.53
33011	Repeat drainage of heart sac	Y		A2	5.1392	$215.53
33206	Insertion of heart pacemaker	Y		J8	162.5435	$6,816.91
33207	Insertion of heart pacemaker	Y		J8	162.5435	$6,816.91
33208	Insertion of heart pacemaker	Y		J8	200.1292	$8,393.22
33210	Insertion of heart electrode	Y		G2	48.2352	$2,022.94
33211	Insertion of heart electrode	Y		G2	48.2352	$2,022.94
33212	Insertion of pulse generator	Y		H8	138.3905	$5,803.96
33213	Insertion of pulse generator	Y		H8	157.3125	$6,597.53
33214	Upgrade of pacemaker system	Y		J8	200.1292	$8,393.22
33215	Reposition pacing-defib lead	Y		G2	21.0019	$880.80
33216	Insert 1 electrode pm-defib	Y		G2	48.2352	$2,022.94
33217	Insert 2 electrode pm-defib	Y		G2	48.2352	$2,022.94
33218	Repair lead pace-defib one	Y		G2	21.0019	$880.80
33220	Repair lead pace-defib dual	Y		G2	21.0019	$880.80
33222	Revise pocket pacemaker	Y		A2	15.9002	$666.84
33223	Revise pocket for defib	Y		A2	15.9002	$666.84
33224	Insert pacing lead & connect	Y		J8	223.4936	$9,373.10
33225	L ventric pacing lead add-on	Y		J8	223.4936	$9,373.10
33226	Reposition l ventric lead	Y		G2	21.0019	$880.80
33233	Removal of pacemaker system	Y		A2	21.0019	$880.80
33234	Removal of pacemaker system	Y		G2	21.0019	$880.80
33235	Removal pacemaker electrode	Y		G2	21.0019	$880.80
33240	Insert pulse generator	Y		J8	529.6442	$22,212.75
33241	Remove pulse generator	Y		G2	21.0019	$880.80
33249	Eltrd/insert pace-defib	Y		J8	604.6887	$25,360.04
33282	Implant pat-active ht record	N		J8	112.3582	$4,712.19
33284	Remove pat-active ht record	Y		G2	7.8457	$329.04
33508	Endoscopic vein harvest	N		N1		
34490	Removal of vein clot	Y		G2	38.5417	$1,616.40
35188	Repair blood vessel lesion	Y		A2	38.5417	$1,616.40

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35207	Repair blood vessel lesion	Y		A2	38.5417	$1,616.40
35460	Repair venous blockage	Y		G2	50.7017	$2,126.38
35473	Repair arterial blockage	N	CH	D5		
35475	Repair arterial blockage	Y		G2	50.7017	$2,126.38
35476	Repair venous blockage	Y		G2	50.7017	$2,126.38
35492	Atherectomy, percutaneous	N	CH	D5		
35572	Harvest femoropopliteal vein	N		N1		
35761	Exploration of artery/vein	Y		G2	33.7065	$1,413.62
35875	Removal of clot in graft	Y		A2	38.5417	$1,616.40
35876	Removal of clot in graft	Y		A2	38.5417	$1,616.40
36000	Place needle in vein	N		N1		
36002	Pseudoaneurysm injection trt	N		G2	2.0519	$86.05
36005	Injection ext venography	N		N1		
36010	Place catheter in vein	N		N1		
36011	Place catheter in vein	N		N1		
36012	Place catheter in vein	N		N1		
36013	Place catheter in artery	N		N1		
36014	Place catheter in artery	N		N1		
36015	Place catheter in artery	N		N1		
36100	Establish access to artery	N		N1		
36120	Establish access to artery	N		N1		
36140	Establish access to artery	N		N1		
36147	Access av dial grft for eval	Y		P2	2.1685	$90.94
36148	Access av dial grft for proc	N		N1		
36160	Establish access to aorta	N		N1		
36200	Place catheter in aorta	N		N1		
36215	Place catheter in artery	N		N1		
36216	Place catheter in artery	N		N1		
36217	Place catheter in artery	N		N1		
36218	Place catheter in artery	N		N1		
36245	Place catheter in artery	N		N1		
36246	Place catheter in artery	N		N1		
36247	Place catheter in artery	N		N1		
36248	Place catheter in artery	N		N1		
36260	Insertion of infusion pump	Y		A2	28.4311	$1,192.37
36261	Revision of infusion pump	Y		A2	21.0019	$880.80

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36262	Removal of infusion pump	Y		A2	21.0019	$880.80
36400	Bl draw < 3 yrs fem/jugular	N		N1		
36405	Bl draw < 3 yrs scalp vein	N		N1		
36406	Bl draw < 3 yrs other vein	N		N1		
36410	Non-routine bl draw > 3 yrs	N		N1		
36416	Capillary blood draw	N		N1		
36420	Vein access cutdown < 1 yr	N		R2	0.247	$10.36
36425	Vein access cutdown > 1 yr	N		R2	0.247	$10.36
36430	Blood transfusion service	N		P3		$26.29
36440	Bl push transfuse 2 yr or <	N		R2	3.1333	$131.41
36450	Bl exchange/transfuse nb	N		R2	3.1333	$131.41
36455	Bl exchange/transfuse non-nb	N		G2	3.1333	$131.41
36468	Injection(s) spider veins	Y		R2	0.8409	$35.27
36469	Injection(s) spider veins	Y		R2	0.8409	$35.27
36470	Injection therapy of vein	Y		P2	0.8409	$35.27
36471	Injection therapy of veins	Y		P2	0.8409	$35.27
36475	Endovenous rf 1st vein	Y		A2	40.6413	$1,704.46
36476	Endovenous rf vein add-on	Y		A2	25.3611	$1,063.62
36478	Endovenous laser 1st vein	Y		A2	25.3611	$1,063.62
36479	Endovenous laser vein addon	Y		A2	25.3611	$1,063.62
36481	Insertion of catheter vein	N		N1		
36500	Insertion of catheter vein	N		N1		
36510	Insertion of catheter vein	N		N1		
36511	Apheresis wbc	N		G2	11.4433	$479.92
36512	Apheresis rbc	N		G2	11.4433	$479.92
36513	Apheresis platelets	N		G2	11.4433	$479.92
36514	Apheresis plasma	N		G2	11.4433	$479.92
36515	Apheresis adsorp/reinfuse	N		P2	29.0559	$1,218.58
36516	Apheresis selective	N		P2	29.0559	$1,218.58
36522	Photopheresis	N		G2	29.0559	$1,218.58
36555	Insert non-tunnel cv cath	Y		A2	10.5031	$440.49
36556	Insert non-tunnel cv cath	Y		A2	10.5031	$440.49
36557	Insert tunneled cv cath	Y		A2	23.7156	$994.61
36558	Insert tunneled cv cath	Y		A2	23.7156	$994.61
36560	Insert tunneled cv cath	Y		A2	28.4311	$1,192.37
36561	Insert tunneled cv cath	Y		A2	28.4311	$1,192.37

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36563	Insert tunneled cv cath	Y		A2	28.4311	$1,192.37
36565	Insert tunneled cv cath	Y		A2	28.4311	$1,192.37
36566	Insert tunneled cv cath	Y		A2	28.4311	$1,192.37
36568	Insert picc cath	Y		A2	10.5031	$440.49
36569	Insert picc cath	Y		A2	10.5031	$440.49
36570	Insert picvad cath	Y		A2	23.7156	$994.61
36571	Insert picvad cath	Y		A2	23.7156	$994.61
36575	Repair tunneled cv cath	Y		A2	5.8475	$245.24
36576	Repair tunneled cv cath	Y		A2	10.5031	$440.49
36578	Replace tunneled cv cath	Y		A2	23.7156	$994.61
36580	Replace cvad cath	Y		A2	10.5031	$440.49
36581	Replace tunneled cv cath	Y		A2	23.7156	$994.61
36582	Replace tunneled cv cath	Y		A2	28.4311	$1,192.37
36583	Replace tunneled cv cath	Y		A2	28.4311	$1,192.37
36584	Replace picc cath	Y		A2	10.5031	$440.49
36585	Replace picvad cath	Y		A2	23.7156	$994.61
36589	Removal tunneled cv cath	Y		A2	5.8475	$245.24
36590	Removal tunneled cv cath	Y		A2	10.5031	$440.49
36591	Draw blood off venous device	N		N1		
36592	Collect blood from picc	N		N1		
36593	Declot vascular device	Y		P3		$21.69
36595	Mech remov tunneled cv cath	Y		G2	23.7156	$994.61
36596	Mech remov tunneled cv cath	Y		G2	10.5031	$440.49
36597	Reposition venous catheter	Y		G2	10.5031	$440.49
36598	Inj w/fluor eval cv device	Y		P3		$65.59
36600	Withdrawal of arterial blood	N		N1		
36620	Insertion catheter artery	N		N1		
36625	Insertion catheter artery	N		N1		
36640	Insertion catheter artery	Y		A2	28.4311	$1,192.37
36680	Insert needle bone cavity	Y		G2	1.4506	$60.84
36800	Insertion of cannula	Y		A2	32.4127	$1,359.36
36810	Insertion of cannula	Y		A2	32.4127	$1,359.36
36815	Insertion of cannula	Y		A2	32.4127	$1,359.36
36818	Av fuse uppr arm cephalic	Y		A2	38.5417	$1,616.40
36819	Av fuse uppr arm basilic	Y		A2	38.5417	$1,616.40
36820	Av fusion/forearm vein	Y		A2	38.5417	$1,616.40

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36821	Av fusion direct any site	Y		A2	38.5417	$1,616.40
36825	Artery-vein autograft	Y		A2	38.5417	$1,616.40
36830	Artery-vein nonautograft	Y		A2	38.5417	$1,616.40
36831	Open thrombect av fistula	Y		A2	38.5417	$1,616.40
36832	Av fistula revision open	Y		A2	38.5417	$1,616.40
36833	Av fistula revision	Y		A2	38.5417	$1,616.40
36835	Artery to vein shunt	Y		A2	32.4127	$1,359.36
36860	External cannula declotting	Y		A2	2.1685	$90.94
36861	Cannula declotting	Y		A2	32.4127	$1,359.36
36870	Percut thrombect av fistula	Y		A2	41.6635	$1,747.33
37184	Prim art mech thrombectomy	Y		G2	38.5417	$1,616.40
37185	Prim art m-thrombect add-on	Y		G2	38.5417	$1,616.40
37186	Sec art m-thrombect add-on	Y		G2	38.5417	$1,616.40
37187	Venous mech thrombectomy	Y		G2	38.5417	$1,616.40
37188	Venous m-thrombectomy add-on	Y		G2	38.5417	$1,616.40
37200	Transcatheter biopsy	Y		G2	28.4311	$1,192.37
37203	Transcatheter retrieval	Y		G2	28.4311	$1,192.37
37204	Transcatheter occlusion	Y	CH	G2	85.6595	$3,592.47
37205	Transcath iv stent percut	Y	NI	P3		$3,035.30
37206	Transcath iv stent/perc addl	Y	NI	P3		$1,850.07
37210	Embolization uterine fibroid	Y	CH	G2	107.6388	$4,514.26
37220	Iliac revasc	Y	NI	G2	50.7017	$2,126.38
37221	Iliac revasc w/stent	Y	NI	G2	50.7017	$2,126.38
37222	Iliac revasc add-on	Y	NI	G2	50.7017	$2,126.38
37223	Iliac revasc w/stent add-on	Y	NI	G2	50.7017	$2,126.38
37250	Iv us first vessel add-on	N		N1		
37251	Iv us each add vessel add-on	N		N1		
37500	Endoscopy ligate perf veins	Y		A2	40.6413	$1,704.46
37607	Ligation of a-v fistula	Y		A2	25.3611	$1,063.62
37609	Temporal artery procedure	Y		A2	16.7008	$700.41
37650	Revision of major vein	Y		A2	25.3611	$1,063.62
37700	Revise leg vein	Y		A2	25.3611	$1,063.62
37718	Ligate/strip short leg vein	Y		A2	25.3611	$1,063.62
37722	Ligate/strip long leg vein	Y		A2	40.6413	$1,704.46
37735	Removal of leg veins/lesion	Y		A2	40.6413	$1,704.46
37760	Ligate leg veins radical	Y		A2	25.3611	$1,063.62

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
37761*	Ligate leg veins open	Y		R2	25.3611	$1,063.62
37765	Stab phleb veins xtr 10-20	Y		P3		$273.59
37766	Phleb veins - extrem 20+	Y		P3		$309.83
37780	Revision of leg vein	Y		A2	25.3611	$1,063.62
37785	Ligate/divide/excise vein	Y		A2	25.3611	$1,063.62
37790	Penile venous occlusion	Y		A2	33.2073	$1,392.68
38200	Injection for spleen x-ray	N		N1		
38204	Bl donor search management	N		N1		
38206	Harvest auto stem cells	N		G2	11.4433	$479.92
38220	Bone marrow aspiration	Y		P3		$83.71
38221	Bone marrow biopsy	Y		P3		$86.01
38230	Bone marrow collection	N		G2	29.0559	$1,218.58
38241	Bone marrow/stem transplant	N		G2	29.0559	$1,218.58
38242	Lymphocyte infuse transplant	N		R2	11.4433	$479.92
38300	Drainage lymph node lesion	Y		A2	12.0213	$504.16
38305	Drainage lymph node lesion	Y		A2	18.6604	$782.60
38308	Incision of lymph channels	Y		A2	23.1511	$970.93
38500	Biopsy/removal lymph nodes	Y		A2	23.1511	$970.93
38505	Needle biopsy lymph nodes	Y		A2	7.5162	$315.22
38510	Biopsy/removal lymph nodes	Y		A2	23.1511	$970.93
38520	Biopsy/removal lymph nodes	Y		A2	23.1511	$970.93
38525	Biopsy/removal lymph nodes	Y		A2	23.1511	$970.93
38530	Biopsy/removal lymph nodes	Y		A2	23.1511	$970.93
38542	Explore deep node(s) neck	Y		A2	46.9119	$1,967.44
38550	Removal neck/armpit lesion	Y		A2	23.1511	$970.93
38555	Removal neck/armpit lesion	Y		A2	23.1511	$970.93
38570	Laparoscopy lymph node biop	Y		A2	44.1995	$1,853.68
38571	Laparoscopy lymphadenectomy	Y		A2	65.6803	$2,754.57
38572	Laparoscopy lymphadenectomy	Y		A2	44.1995	$1,853.68
38700	Removal of lymph nodes neck	Y		G2	23.1511	$970.93
38740	Remove armpit lymph nodes	Y		A2	46.9119	$1,967.44
38745	Remove armpit lymph nodes	Y		A2	46.9119	$1,967.44
38760	Remove groin lymph nodes	Y		A2	23.1511	$970.93

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
38790	Inject for lymphatic x-ray	N		N1		
38792	Identify sentinel node	N		N1		
38794	Access thoracic lymph duct	N		N1		
38900	Io map of sent lymph node	N	NI	N1		
40490	Biopsy of lip	Y		P3		$61.51
40500	Partial excision of lip	Y		A2	16.0176	$671.76
40510	Partial excision of lip	Y		A2	23.6929	$993.66
40520	Partial excision of lip	Y		A2	16.0176	$671.76
40525	Reconstruct lip with flap	Y		A2	23.6929	$993.66
40527	Reconstruct lip with flap	Y		A2	23.6929	$993.66
40530	Partial removal of lip	Y		A2	23.6929	$993.66
40650	Repair lip	Y		A2	7.3159	$306.82
40652	Repair lip	Y		A2	7.3159	$306.82
40654	Repair lip	Y		A2	7.3159	$306.82
40700	Repair cleft lip/nasal	Y		A2	41.2845	$1,731.43
40701	Repair cleft lip/nasal	Y		A2	41.2845	$1,731.43
40702	Repair cleft lip/nasal	Y		R2	41.2845	$1,731.43
40720	Repair cleft lip/nasal	Y		A2	41.2845	$1,731.43
40761	Repair cleft lip/nasal	Y		A2	41.2845	$1,731.43
40800	Drainage of mouth lesion	Y		P2	1.377	$57.75
40801	Drainage of mouth lesion	Y		A2	7.3159	$306.82
40804	Removal foreign body mouth	N		P2	0.6201	$26.01
40805	Removal foreign body mouth	Y		P3		$160.79
40806	Incision of lip fold	Y		P3		$70.18
40808	Biopsy of mouth lesion	Y		P3		$108.98
40810	Excision of mouth lesion	Y		P3		$113.57
40812	Excise/repair mouth lesion	Y		P3		$143.94
40814	Excise/repair mouth lesion	Y		A2	16.0176	$671.76
40816	Excision of mouth lesion	Y		A2	23.6929	$993.66
40818	Excise oral mucosa for graft	Y		A2	3.283	$137.69
40819	Excise lip or cheek fold	Y		A2	7.3159	$306.82
40820	Treatment of mouth lesion	Y		P3		$159.26
40830	Repair mouth laceration	Y		G2	3.283	$137.69
40831	Repair mouth laceration	Y		A2	7.3159	$306.82
40840	Reconstruction of mouth	Y		A2	23.6929	$993.66
40842	Reconstruction of mouth	Y		A2	23.6929	$993.66

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
40843	Reconstruction of mouth	Y		A2	23.6929	$993.66
40844	Reconstruction of mouth	Y		A2	41.2845	$1,731.43
40845	Reconstruction of mouth	Y		A2	41.2845	$1,731.43
41000	Drainage of mouth lesion	Y		P3		$81.41
41005	Drainage of mouth lesion	Y		A2	3.283	$137.69
41006	Drainage of mouth lesion	Y		A2	23.6929	$993.66
41007	Drainage of mouth lesion	Y		A2	16.0176	$671.76
41008	Drainage of mouth lesion	Y		A2	16.0176	$671.76
41009	Drainage of mouth lesion	Y		A2	3.283	$137.69
41010	Incision of tongue fold	Y		A2	7.3159	$306.82
41015	Drainage of mouth lesion	Y		A2	3.283	$137.69
41016	Drainage of mouth lesion	Y		A2	7.3159	$306.82
41017	Drainage of mouth lesion	Y		A2	7.3159	$306.82
41018	Drainage of mouth lesion	Y		A2	7.3159	$306.82
41019	Place needles h&n for rt	Y		G2	23.6929	$993.66
41100	Biopsy of tongue	Y		P3		$85.24
41105	Biopsy of tongue	Y		P3		$84.99
41108	Biopsy of floor of mouth	Y		P3		$78.61
41110	Excision of tongue lesion	Y		P3		$113.83
41112	Excision of tongue lesion	Y		A2	16.0176	$671.76
41113	Excision of tongue lesion	Y		A2	16.0176	$671.76
41114	Excision of tongue lesion	Y		A2	23.6929	$993.66
41115	Excision of tongue fold	Y		P3		$130.93
41116	Excision of mouth lesion	Y		A2	16.0176	$671.76
41120	Partial removal of tongue	Y		A2	23.6929	$993.66
41250	Repair tongue laceration	Y		A2	1.0468	$43.90
41251	Repair tongue laceration	Y		A2	3.283	$137.69
41252	Repair tongue laceration	Y		A2	7.3159	$306.82
41500	Fixation of tongue	Y		A2	23.6929	$993.66
41510	Tongue to lip surgery	Y		A2	16.0176	$671.76
41512	Tongue suspension	Y		G2	7.3159	$306.82
41520	Reconstruction tongue fold	Y		A2	7.3159	$306.82
41530	Tongue base vol reduction	Y		G2	23.6929	$993.66
41800	Drainage of gum lesion	Y		A2	1.377	$57.75
41805	Removal foreign body gum	Y		P3		$140.88
41806	Removal foreign body jawbone	Y		P3		$181.71

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41820	Excision gum each quadrant	Y		R2	7.3159	$306.82
41821	Excision of gum flap	Y		G2	7.3159	$306.82
41822	Excision of gum lesion	Y		P3		$144.71
41823	Excision of gum lesion	Y		P3		$209.28
41825	Excision of gum lesion	Y		P3		$114.59
41826	Excision of gum lesion	Y		P3		$154.15
41827	Excision of gum lesion	Y		A2	23.6929	$993.66
41828	Excision of gum lesion	Y		P3		$135.27
41830	Removal of gum tissue	Y		P3		$189.37
41850	Treatment of gum lesion	Y		R2	16.0176	$671.76
41870	Gum graft	Y		G2	23.6929	$993.66
41872	Repair gum	Y		P3		$183.76
41874	Repair tooth socket	Y		P3		$182.22
42000	Drainage mouth roof lesion	Y		A2	3.283	$137.69
42100	Biopsy roof of mouth	Y		P3		$72.99
42104	Excision lesion mouth roof	Y		P3		$110.76
42106	Excision lesion mouth roof	Y		P3		$138.33
42107	Excision lesion mouth roof	Y		A2	23.6929	$993.66
42120	Remove palate/lesion	Y		A2	41.2845	$1,731.43
42140	Excision of uvula	Y		A2	7.3159	$306.82
42145	Repair palate pharynx/uvula	Y		A2	23.6929	$993.66
42160	Treatment mouth roof lesion	Y		P3		$124.55
42180	Repair palate	Y		A2	3.283	$137.69
42182	Repair palate	Y		A2	41.2845	$1,731.43
42200	Reconstruct cleft palate	Y		A2	41.2845	$1,731.43
42205	Reconstruct cleft palate	Y		A2	41.2845	$1,731.43
42210	Reconstruct cleft palate	Y		A2	41.2845	$1,731.43
42215	Reconstruct cleft palate	Y		A2	41.2845	$1,731.43
42220	Reconstruct cleft palate	Y		A2	41.2845	$1,731.43
42225	Reconstruct cleft palate	Y		G2	41.2845	$1,731.43
42226	Lengthening of palate	Y		A2	41.2845	$1,731.43
42227	Lengthening of palate	Y		G2	41.2845	$1,731.43
42235	Repair palate	Y		A2	16.0176	$671.76
42260	Repair nose to lip fistula	Y		A2	23.6929	$993.66
42280	Preparation palate mold	Y		P3		$73.50
42281	Insertion palate prosthesis	Y		G2	16.0176	$671.76

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42300	Drainage of salivary gland	Y		A2	16.0176	$671.76
42305	Drainage of salivary gland	Y		A2	16.0176	$671.76
42310	Drainage of salivary gland	Y		A2	3.283	$137.69
42320	Drainage of salivary gland	Y		A2	3.283	$137.69
42330	Removal of salivary stone	Y		P3		$110.25
42335	Removal of salivary stone	Y		P3		$183.76
42340	Removal of salivary stone	Y		A2	16.0176	$671.76
42400	Biopsy of salivary gland	Y		P3		$59.47
42405	Biopsy of salivary gland	Y		A2	23.6929	$993.66
42408	Excision of salivary cyst	Y		A2	16.0176	$671.76
42409	Drainage of salivary cyst	Y		A2	16.0176	$671.76
42410	Excise parotid gland/lesion	Y		A2	41.2845	$1,731.43
42415	Excise parotid gland/lesion	Y		A2	41.2845	$1,731.43
42420	Excise parotid gland/lesion	Y		A2	41.2845	$1,731.43
42425	Excise parotid gland/lesion	Y		A2	41.2845	$1,731.43
42440	Excise submaxillary gland	Y		A2	41.2845	$1,731.43
42450	Excise sublingual gland	Y		A2	23.6929	$993.66
42500	Repair salivary duct	Y		A2	23.6929	$993.66
42505	Repair salivary duct	Y		A2	41.2845	$1,731.43
42507	Parotid duct diversion	Y		A2	41.2845	$1,731.43
42508	Parotid duct diversion	Y		A2	41.2845	$1,731.43
42509	Parotid duct diversion	Y		A2	41.2845	$1,731.43
42510	Parotid duct diversion	Y		A2	41.2845	$1,731.43
42550	Injection for salivary x-ray	N		N1		
42600	Closure of salivary fistula	Y		A2	16.0176	$671.76
42650	Dilation of salivary duct	Y		P3		$40.83
42660	Dilation of salivary duct	Y		P3		$47.98
42665	Ligation of salivary duct	Y		A2	23.6929	$993.66
42700	Drainage of tonsil abscess	Y		A2	3.283	$137.69
42720	Drainage of throat abscess	Y		A2	16.0176	$671.76
42725	Drainage of throat abscess	Y		A2	41.2845	$1,731.43
42800	Biopsy of throat	Y		P3		$78.61
42802	Biopsy of throat	Y		A2	16.0176	$671.76
42804	Biopsy of upper nose/throat	Y		A2	16.0176	$671.76
42806	Biopsy of upper nose/throat	Y		A2	23.6929	$993.66
42808	Excise pharynx lesion	Y		A2	23.6929	$993.66

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42809	Remove pharynx foreign body	N		G2	0.6201	$26.01
42810	Excision of neck cyst	Y		A2	23.6929	$993.66
42815	Excision of neck cyst	Y		A2	41.2845	$1,731.43
42820	Remove tonsils and adenoids	Y		A2	23.6929	$993.66
42821	Remove tonsils and adenoids	Y		A2	23.6929	$993.66
42825	Removal of tonsils	Y		A2	23.6929	$993.66
42826	Removal of tonsils	Y		A2	23.6929	$993.66
42830	Removal of adenoids	Y		A2	23.6929	$993.66
42831	Removal of adenoids	Y		A2	23.6929	$993.66
42835	Removal of adenoids	Y		A2	23.6929	$993.66
42836	Removal of adenoids	Y		A2	23.6929	$993.66
42860	Excision of tonsil tags	Y		A2	23.6929	$993.66
42870	Excision of lingual tonsil	Y		A2	23.6929	$993.66
42890	Partial removal of pharynx	Y		A2	41.2845	$1,731.43
42892	Revision of pharyngeal walls	Y		A2	41.2845	$1,731.43
42900	Repair throat wound	Y		A2	7.3159	$306.82
42950	Reconstruction of throat	Y		A2	23.6929	$993.66
42955	Surgical opening of throat	Y		A2	23.6929	$993.66
42960	Control throat bleeding	Y		A2	1.0468	$43.90
42962	Control throat bleeding	Y		A2	41.2845	$1,731.43
42970	Control nose/throat bleeding	Y		R2	1.0468	$43.90
42972	Control nose/throat bleeding	Y		A2	16.0176	$671.76
43030	Throat muscle surgery	Y		G2	16.0176	$671.76
43130	Removal of esophagus pouch	Y		G2	41.2845	$1,731.43
43200	Esophagus endoscopy	Y		A2	8.2048	$344.10
43201	Esoph scope w/submucous inj	Y		A2	8.2048	$344.10
43202	Esophagus endoscopy biopsy	Y		A2	8.2048	$344.10
43204	Esoph scope w/sclerosis inj	Y		A2	8.2048	$344.10
43205	Esophagus endoscopy/ligation	Y		A2	8.2048	$344.10
43215	Esophagus endoscopy	Y		A2	8.2048	$344.10
43216	Esophagus endoscopy/lesion	Y		A2	15.4076	$646.18
43217	Esophagus endoscopy	Y		A2	8.2048	$344.10
43219	Esophagus endoscopy	Y		A2	25.6908	$1,077.45
43220	Esoph endoscopy dilation	Y		A2	8.2048	$344.10

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43226	Esoph endoscopy dilation	Y		A2	8.2048	$344.10
43227	Esoph endoscopy repair	Y		A2	8.2048	$344.10
43228	Esoph endoscopy ablation	Y		A2	15.4076	$646.18
43231	Esoph endoscopy w/us exam	Y		A2	8.2048	$344.10
43232	Esoph endoscopy w/us fn bx	Y		A2	8.2048	$344.10
43234	Upper gi endoscopy exam	Y		A2	8.2048	$344.10
43235	Uppr gi endoscopy diagnosis	Y		A2	8.2048	$344.10
43236	Uppr gi scope w/submuc inj	Y		A2	8.2048	$344.10
43237	Endoscopic us exam esoph	Y		A2	8.2048	$344.10
43238	Uppr gi endoscopy w/us fn bx	Y		A2	8.2048	$344.10
43239	Upper gi endoscopy biopsy	Y		A2	8.2048	$344.10
43240	Esoph endoscope w/drain cyst	Y		A2	8.2048	$344.10
43241	Upper GI endoscopy with tube	Y		A2	8.2048	$344.10
43242	Uppr gi endoscopy w/us fn bx	Y		A2	15.4076	$646.18
43243	Upper gi endoscopy & inject	Y		A2	8.2048	$344.10
43244	Upper GI endoscopy/ligation	Y		A2	8.2048	$344.10
43245	Uppr gi scope dilate strictr	Y		A2	8.2048	$344.10
43246	Place gastrostomy tube	Y		A2	8.2048	$344.10
43247	Operative upper GI endoscopy	Y		A2	8.2048	$344.10
43248	Uppr gi endoscopy/guide wire	Y		A2	8.2048	$344.10
43249	Esoph endoscopy dilation	Y		A2	8.2048	$344.10
43250	Upper GI endoscopy/tumor	Y		A2	8.2048	$344.10
43251	Operative upper GI endoscopy	Y		A2	8.2048	$344.10
43255	Operative upper GI endoscopy	Y		A2	8.2048	$344.10
43256	Uppr gi endoscopy w/stent	Y		A2	25.6908	$1,077.45
43257	Uppr gi scope w/thrml txmnt	Y		A2	15.4076	$646.18
43258	Operative upper GI endoscopy	Y		A2	8.2048	$344.10
43259	Endoscopic ultrasound exam	Y		A2	8.2048	$344.10
43260	Endo cholangiopancreatograph	Y		A2	21.4651	$900.22
43261	Endo cholangiopancreatograph	Y		A2	21.4651	$900.22

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43262	Endo cholangiopancreatograph	Y		A2	21.4651	$900.22
43263	Endo cholangiopancreatograph	Y		A2	21.4651	$900.22
43264	Endo cholangiopancreatograph	Y		A2	21.4651	$900.22
43265	Endo cholangiopancreatograph	Y		A2	21.4651	$900.22
43267	Endo cholangiopancreatograph	Y		A2	21.4651	$900.22
43268	Endo cholangiopancreatograph	Y		A2	25.6908	$1,077.45
43269	Endo cholangiopancreatograph	Y		A2	25.6908	$1,077.45
43271	Endo cholangiopancreatograph	Y		A2	21.4651	$900.22
43272	Endo cholangiopancreatograph	Y		A2	21.4651	$900.22
43273	Endoscopic pancreatoscopy	Y		G2	21.4651	$900.22
43450	Dilate esophagus	Y		A2	6.0635	$254.30
43453	Dilate esophagus	Y		A2	6.0635	$254.30
43456	Dilate esophagus	Y		A2	6.0635	$254.30
43458	Dilate esophagus	Y		A2	8.2048	$344.10
43600	Biopsy of stomach	N	CH	D5		
43653	Laparoscopy gastrostomy	Y		A2	44.1995	$1,853.68
43752	Nasal/orogastric w/stent	N		G2	1.1199	$46.97
43753	Tx gastro intub w/asp	N	NI	G2	0.6201	$26.01
43754	Dx gastr intub w/asp spec	N	NI	G2	0.6201	$26.01
43755	Dx gastr intub w/asp specs	N	NI	G2	0.8886	$37.27
43756	Dx duod intub w/asp spec	N	NI	G2	1.1199	$46.97
43757	Dx duod intub w/asp specs	N	NI	G2	1.1199	$46.97
43760	Change gastrostomy tube	Y		A2	2.1685	$90.94
43761	Reposition gastrostomy tube	Y		A2	8.2048	$344.10
43870	Repair stomach opening	Y		A2	15.4076	$646.18
43886	Revise gastric port open	Y		G2	20.5842	$863.28
43887	Remove gastric port open	Y		G2	4.2885	$179.86
43888	Change gastric port open	Y		G2	20.5842	$863.28
44100	Biopsy of bowel	Y		A2	8.2048	$344.10

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44312	Revision of ileostomy	Y		A2	20.5842	$863.28
44340	Revision of colostomy	Y		A2	20.5842	$863.28
44360	Small bowel endoscopy	Y		A2	9.4095	$394.63
44361	Small bowel endoscopy/biopsy	Y		A2	9.4095	$394.63
44363	Small bowel endoscopy	Y		A2	9.4095	$394.63
44364	Small bowel endoscopy	Y		A2	9.4095	$394.63
44365	Small bowel endoscopy	Y		A2	9.4095	$394.63
44366	Small bowel endoscopy	Y		A2	9.4095	$394.63
44369	Small bowel endoscopy	Y		A2	9.4095	$394.63
44370	Small bowel endoscopy/stent	Y		A2	25.6908	$1,077.45
44372	Small bowel endoscopy	Y		A2	9.4095	$394.63
44373	Small bowel endoscopy	Y		A2	9.4095	$394.63
44376	Small bowel endoscopy	Y		A2	9.4095	$394.63
44377	Small bowel endoscopy/biopsy	Y		A2	9.4095	$394.63
44378	Small bowel endoscopy	Y		A2	9.4095	$394.63
44379	S bowel endoscope w/stent	Y		A2	25.6908	$1,077.45
44380	Small bowel endoscopy	Y		A2	9.4095	$394.63
44382	Small bowel endoscopy	Y		A2	9.4095	$394.63
44383	Ileoscopy w/stent	Y		A2	25.6908	$1,077.45
44385	Endoscopy of bowel pouch	Y		A2	8.6298	$361.93
44386	Endoscopy bowel pouch/biop	Y		A2	8.6298	$361.93
44388	Colonoscopy	Y		A2	8.6298	$361.93
44389	Colonoscopy with biopsy	Y		A2	8.6298	$361.93
44390	Colonoscopy for foreign body	Y		A2	8.6298	$361.93
44391	Colonoscopy for bleeding	Y		A2	8.6298	$361.93
44392	Colonoscopy & polypectomy	Y		A2	8.6298	$361.93
44393	Colonoscopy lesion removal	Y		A2	8.6298	$361.93
44394	Colonoscopy w/snare	Y		A2	8.6298	$361.93
44397	Colonoscopy w/stent	Y		A2	25.6908	$1,077.45
44500	Intro gastrointestinal tube	Y		G2	5.8475	$245.24
44701	Intraop colon lavage add-on	N		N1		
45000	Drainage of pelvic abscess	Y		A2	14.8848	$624.25
45005	Drainage of rectal abscess	Y		A2	14.8848	$624.25
45020	Drainage of rectal abscess	Y		A2	14.8848	$624.25
45100	Biopsy of rectum	Y		A2	22.4899	$943.20

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
45108	Removal of anorectal lesion	Y		A2	22.4899	$943.20
45150	Excision of rectal stricture	Y		A2	22.4899	$943.20
45160	Excision of rectal lesion	Y		A2	22.4899	$943.20
45171	Exc rect tum transanal part	Y		G2	14.8848	$624.25
45172	Exc rect tum transanal full	Y		G2	22.4899	$943.20
45190	Destruction rectal tumor	Y		A2	22.4899	$943.20
45300	Proctosigmoidoscopy dx	Y		P3		$62.02
45303	Proctosigmoidoscopy dilate	Y		P2	8.7802	$368.23
45305	Proctosigmoidoscopy w/bx	Y		A2	8.7802	$368.23
45307	Proctosigmoidoscopy fb	Y		A2	22.5446	$945.50
45308	Proctosigmoidoscopy removal	Y		A2	8.7802	$368.23
45309	Proctosigmoidoscopy removal	Y		A2	8.7802	$368.23
45315	Proctosigmoidoscopy removal	Y		A2	8.7802	$368.23
45317	Proctosigmoidoscopy bleed	Y		A2	8.7802	$368.23
45320	Proctosigmoidoscopy ablate	Y		A2	22.5446	$945.50
45321	Proctosigmoidoscopy volvul	Y		A2	22.5446	$945.50
45327	Proctosigmoidoscopy w/stent	Y		A2	25.6908	$1,077.45
45330	Diagnostic sigmoidoscopy	Y		P3		$75.54
45331	Sigmoidoscopy and biopsy	Y		A2	5.3564	$224.64
45332	Sigmoidoscopy w/fb removal	Y		A2	5.3564	$224.64
45333	Sigmoidoscopy & polypectomy	Y		A2	8.7802	$368.23
45334	Sigmoidoscopy for bleeding	Y		A2	8.7802	$368.23
45335	Sigmoidoscopy w/submuc inj	Y		A2	5.3564	$224.64
45337	Sigmoidoscopy & decompress	Y		A2	5.3564	$224.64
45338	Sigmoidoscopy w/tumr remove	Y		A2	8.7802	$368.23
45339	Sigmoidoscopy w/ablate tumr	Y		A2	8.7802	$368.23
45340	Sig w/balloon dilation	Y		A2	8.7802	$368.23
45341	Sigmoidoscopy w/ultrasound	Y		A2	8.7802	$368.23
45342	Sigmoidoscopy w/us guide bx	Y		A2	8.7802	$368.23
45345	Sigmoidoscopy w/stent	Y		A2	25.6908	$1,077.45
45355	Surgical colonoscopy	Y		A2	8.6298	$361.93
45378	Diagnostic colonoscopy	Y		A2	8.6298	$361.93

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45379	Colonoscopy w/fb removal	Y		A2	8.6298	$361.93
45380	Colonoscopy and biopsy	Y		A2	8.6298	$361.93
45381	Colonoscopy submucous inj	Y		A2	8.6298	$361.93
45382	Colonoscopy/control bleeding	Y		A2	8.6298	$361.93
45383	Lesion removal colonoscopy	Y		A2	8.6298	$361.93
45384	Lesion remove colonoscopy	Y		A2	8.6298	$361.93
45385	Lesion removal colonoscopy	Y		A2	8.6298	$361.93
45386	Colonoscopy dilate stricture	Y		A2	8.6298	$361.93
45387	Colonoscopy w/stent	Y		A2	25.6908	$1,077.45
45391	Colonoscopy w/endoscope us	Y		A2	8.6298	$361.93
45392	Colonoscopy w/endoscopic fnb	Y		A2	8.6298	$361.93
45500	Repair of rectum	Y		A2	22.4899	$943.20
45505	Repair of rectum	Y		A2	30.1708	$1,265.33
45520	Treatment of rectal prolapse	Y		P2	0.8409	$35.27
45541	Correct rectal prolapse	Y		G2	30.1708	$1,265.33
45560	Repair of rectocele	Y		A2	30.1708	$1,265.33
45900	Reduction of rectal prolapse	Y		A2	5.5574	$233.07
45905	Dilation of anal sphincter	Y		A2	22.4899	$943.20
45910	Dilation of rectal narrowing	Y		A2	22.4899	$943.20
45915	Remove rectal obstruction	Y		A2	14.8848	$624.25
45990	Surg dx exam anorectal	Y		A2	22.4899	$943.20
46020	Placement of seton	Y		A2	22.4899	$943.20
46030	Removal of rectal marker	Y		A2	5.5574	$233.07
46040	Incision of rectal abscess	Y		A2	22.4899	$943.20
46045	Incision of rectal abscess	Y		A2	22.4899	$943.20
46050	Incision of anal abscess	Y		A2	14.8848	$624.25
46060	Incision of rectal abscess	Y		A2	22.4899	$943.20
46070	Incision of anal septum	Y		G2	14.8848	$624.25
46080	Incision of anal sphincter	Y		A2	22.4899	$943.20
46083	Incise external hemorrhoid	Y		P2	1.8817	$78.92
46200	Removal of anal fissure	Y		A2	22.4899	$943.20
46220	Excise anal ext tag/papilla	Y		A2	14.8848	$624.25
46221	Ligation of hemorrhoid(s)	Y		P3		$118.17
46230	Removal of anal tags	Y		A2	22.4899	$943.20
46250	Remove ext hem groups 2+	Y		A2	22.4899	$943.20
46255	Remove int/ext hem 1 group	Y		A2	22.4899	$943.20

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46257	Remove in/ex hem grp & fiss	Y		A2	22.4899	$943.20
46258	Remove in/ex hem grp w/fistu	Y		A2	22.4899	$943.20
46260	Remove in/ex hem groups 2+	Y		A2	22.4899	$943.20
46261	Remove in/ex hem grps & fiss	Y		A2	22.4899	$943.20
46262	Remove in/ex hem grps w/fist	Y		A2	22.4899	$943.20
46270	Remove anal fist subq	Y		A2	22.4899	$943.20
46275	Remove anal fist inter	Y		A2	22.4899	$943.20
46280	Remove anal fist complex	Y		A2	22.4899	$943.20
46285	Remove anal fist 2 stage	Y		A2	22.4899	$943.20
46288	Repair anal fistula	Y		A2	22.4899	$943.20
46320	Removal of hemorrhoid clot	Y		P3		$79.63
46500	Injection into hemorrhoid(s)	Y		P3		$112.04
46505	Chemodenervation anal musc	Y		G2	22.4899	$943.20
46600	Diagnostic anoscopy	N		P2	0.6201	$26.01
46604	Anoscopy and dilation	Y		P2	8.7802	$368.23
46606	Anoscopy and biopsy	Y		P3		$123.53
46608	Anoscopy remove for body	Y		A2	8.7802	$368.23
46610	Anoscopy remove lesion	Y		A2	22.5446	$945.50
46611	Anoscopy	Y		A2	8.7802	$368.23
46612	Anoscopy remove lesions	Y		A2	22.5446	$945.50
46614	Anoscopy control bleeding	Y		P3		$63.55
46615	Anoscopy	Y		A2	22.5446	$945.50
46700	Repair of anal stricture	Y		A2	22.4899	$943.20
46706	Repr of anal fistula w/glue	Y		A2	30.1708	$1,265.33
46707	Repair anorectal fist w/plug	Y		G2	30.1708	$1,265.33
46750	Repair of anal sphincter	Y		A2	30.1708	$1,265.33
46753	Reconstruction of anus	Y		A2	22.4899	$943.20
46754	Removal of suture from anus	Y		A2	22.4899	$943.20
46760	Repair of anal sphincter	Y		A2	30.1708	$1,265.33
46761	Repair of anal sphincter	Y		A2	30.1708	$1,265.33
46762	Implant artificial sphincter	Y		A2	30.1708	$1,265.33
46900	Destruction anal lesion(s)	Y		P2	2.5236	$105.84
46910	Destruction anal lesion(s)	Y		P3		$119.95
46916	Cryosurgery anal lesion(s)	Y		P2	1.3834	$58.02
46917	Laser surgery anal lesions	Y		A2	20.136	$844.48
46922	Excision of anal lesion(s)	Y		A2	20.136	$844.48

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46924	Destruction anal lesion(s)	Y		A2	20.136	$844.48
46930	Destroy internal hemorrhoids	Y		P3		$105.92
46940	Treatment of anal fissure	Y		P3		$91.62
46942	Treatment of anal fissure	Y		P3		$89.33
46945	Remove by ligat int hem grp	Y		P3		$147.26
46946	Remove by ligat int hem grps	Y		A2	14.8848	$624.25
46947	Hemorrhoidopexy by stapling	Y		A2	30.1708	$1,265.33
47000	Needle biopsy of liver	Y		A2	8.9935	$377.18
47001	Needle biopsy liver add-on	N		N1		
47382	Percut ablate liver rf	Y		G2	52.256	$2,191.56
47500	Injection for liver x-rays	N		N1		
47505	Injection for liver x-rays	N		N1		
47510	Insert catheter bile duct	Y		A2	29.3173	$1,229.54
47511	Insert bile duct drain	Y		A2	29.3173	$1,229.54
47525	Change bile duct catheter	Y		A2	15.0738	$632.18
47530	Revise/reinsert bile tube	Y		A2	15.0738	$632.18
47552	Biliary endoscopy thru skin	Y		A2	29.3173	$1,229.54
47553	Biliary endoscopy thru skin	Y		A2	29.3173	$1,229.54
47554	Biliary endoscopy thru skin	Y		A2	29.3173	$1,229.54
47555	Biliary endoscopy thru skin	Y		A2	29.3173	$1,229.54
47556	Biliary endoscopy thru skin	Y		A2	29.3173	$1,229.54
47560	Laparoscopy w/cholangio	Y		A2	35.7062	$1,497.48
47561	Laparo w/cholangio/biopsy	Y		A2	35.7062	$1,497.48
47562	Laparoscopic cholecystectomy	Y		G2	44.1995	$1,853.68
47563	Laparo cholecystectomy/graph	Y		G2	44.1995	$1,853.68
47564	Laparo cholecystectomy/explr	Y		G2	44.1995	$1,853.68
47630	Remove bile duct stone	Y		A2	29.3173	$1,229.54
48102	Needle biopsy pancreas	Y		A2	8.9935	$377.18
49080	Puncture peritoneal cavity	Y		A2	5.1392	$215.53
49081	Removal of abdominal fluid	Y		A2	5.1392	$215.53
49180	Biopsy abdominal mass	Y		A2	8.9935	$377.18
49250	Excision of umbilicus	Y		A2	24.4649	$1,026.03
49320	Diag laparo separate proc	Y		A2	35.7062	$1,497.48
49321	Laparoscopy biopsy	Y		A2	35.7062	$1,497.48
49322	Laparoscopy aspiration	Y		A2	35.7062	$1,497.48

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49324	Lap insert tunnel ip cath	Y		G2	35.7062	$1,497.48
49325	Lap revision perm ip cath	Y		G2	35.7062	$1,497.48
49326	Lap w/omentopexy add-on	Y		G2	35.7062	$1,497.48
49327	Lap ins device for rt	Y	NI	G2	35.7062	$1,497.48
49400	Air injection into abdomen	N		N1		
49402	Remove foreign body adbomen	Y		A2	24.4649	$1,026.03
49411	Ins mark abd/pel for rt perq	N		P3		$288.91
49418	Insert tun ip cath perc	Y	NI	G2	28.6387	$1,201.08
49419	Insert tun ip cath w/port	Y		A2	32.4127	$1,359.36
49420	Insert abdom drain, temp	N	CH	D5		
49421	Ins tun ip cath for dial opn	Y		A2	28.6387	$1,201.08
49422	Remove tunneled ip cath	Y		A2	21.0019	$880.80
49423	Exchange drainage catheter	Y		G2	15.0738	$632.18
49424	Assess cyst contrast inject	N		N1		
49426	Revise abdomen-venous shunt	Y		A2	24.4649	$1,026.03
49427	Injection abdominal shunt	N		N1		
49429	Removal of shunt	Y		G2	21.0019	$880.80
49435	Insert subq exten to ip cath	Y		G2	15.0738	$632.18
49436	Embedded ip cath exit-site	Y		G2	15.0738	$632.18
49440	Place gastrostomy tube perc	Y		G2	8.2048	$344.10
49441	Place duod/jej tube perc	Y		G2	8.2048	$344.10
49442	Place cecostomy tube perc	Y		G2	14.8848	$624.25
49446	Change g-tube to g-j perc	Y		G2	8.2048	$344.10
49450	Replace g/c tube perc	Y		G2	5.8475	$245.24
49451	Replace duod/jej tube perc	Y		G2	5.8475	$245.24
49452	Replace g-j tube perc	Y		G2	5.8475	$245.24
49460	Fix g/colon tube w/device	Y		G2	5.8475	$245.24
49465	Fluoro exam of g/colon tube	N		N1		
49495	Rpr ing hernia baby reduc	Y		A2	30.5585	$1,281.59
49496	Rpr ing hernia baby blocked	Y		A2	30.5585	$1,281.59
49500	Rpr ing hernia init reduce	Y		A2	30.5585	$1,281.59
49501	Rpr ing hernia init blocked	Y		A2	30.5585	$1,281.59
49505	Prp i/hern init reduc >5 yr	Y		A2	30.5585	$1,281.59
49507	Prp i/hern init block >5 yr	Y		A2	30.5585	$1,281.59
49520	Rerepair ing hernia reduce	Y		A2	30.5585	$1,281.59

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49521	Rerepair ing hernia blocked	Y		A2	30.5585	$1,281.59
49525	Repair ing hernia sliding	Y		A2	30.5585	$1,281.59
49540	Repair lumbar hernia	Y		A2	30.5585	$1,281.59
49550	Rpr rem hernia init reduce	Y		A2	30.5585	$1,281.59
49553	Rpr fem hernia init blocked	Y		A2	30.5585	$1,281.59
49555	Rerepair fem hernia reduce	Y		A2	30.5585	$1,281.59
49557	Rerepair fem hernia blocked	Y		A2	30.5585	$1,281.59
49560	Rpr ventral hern init reduc	Y		A2	30.5585	$1,281.59
49561	Rpr ventral hern init block	Y		A2	30.5585	$1,281.59
49565	Rerepair ventrl hern reduce	Y		A2	30.5585	$1,281.59
49566	Rerepair ventrl hern block	Y		A2	30.5585	$1,281.59
49568	Hernia repair w/mesh	Y		A2	30.5585	$1,281.59
49570	Rpr epigastric hern reduce	Y		A2	30.5585	$1,281.59
49572	Rpr epigastric hern blocked	Y		A2	30.5585	$1,281.59
49580	Rpr umbil hern reduc < 5 yr	Y		A2	30.5585	$1,281.59
49582	Rpr umbil hern block < 5 yr	Y		A2	30.5585	$1,281.59
49585	Rpr umbil hern reduc > 5 yr	Y		A2	30.5585	$1,281.59
49587	Rpr umbil hern block > 5 yr	Y		A2	30.5585	$1,281.59
49590	Repair spigelian hernia	Y		A2	30.5585	$1,281.59
49600	Repair umbilical lesion	Y		A2	30.5585	$1,281.59
49650	Lap ing hernia repair init	Y		A2	44.1995	$1,853.68
49651	Lap ing hernia repair recur	Y		A2	44.1995	$1,853.68
49652	Lap vent/abd hernia repair	Y		G2	65.6803	$2,754.57
49653	Lap vent/abd hern proc comp	Y		G2	65.6803	$2,754.57
49654	Lap inc hernia repair	Y		G2	65.6803	$2,754.57
49655	Lap inc hern repair comp	Y		G2	65.6803	$2,754.57
49656	Lap inc hernia repair recur	Y		G2	65.6803	$2,754.57
49657	Lap inc hern recur comp	Y		G2	65.6803	$2,754.57
50080	Removal of kidney stone	Y		G2	42.9298	$1,800.43
50081	Removal of kidney stone	Y		G2	42.9298	$1,800.43
50200	Renal biopsy perq	Y		A2	8.9935	$377.18
50382	Change ureter stent percut	Y		G2	24.3268	$1,020.24
50384	Remove ureter stent percut	Y		G2	16.2347	$680.87
50385	Change stent via transureth	Y		G2	24.3268	$1,020.24
50386	Remove stent via transureth	Y		P2	6.8736	$288.27
50387	Change ext/int ureter stent	Y		G2	15.0738	$632.18

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50389	Remove renal tube w/fluoro	Y		G2	6.8736	$288.27
50390	Drainage of kidney lesion	Y		A2	8.9935	$377.18
50391	Instll rx agnt into rnal tub	Y		P3		$42.37
50392	Insert kidney drain	Y		A2	16.2347	$680.87
50393	Insert ureteral tube	Y		A2	24.3268	$1,020.24
50394	Injection for kidney x-ray	N		N1		
50395	Create passage to kidney	Y		A2	24.3268	$1,020.24
50396	Measure kidney pressure	Y		A2	1.8817	$78.92
50398	Change kidney tube	Y		A2	15.0738	$632.18
50551	Kidney endoscopy	Y		A2	6.8736	$288.27
50553	Kidney endoscopy	Y		A2	24.3268	$1,020.24
50555	Kidney endoscopy & biopsy	Y		A2	6.8736	$288.27
50557	Kidney endoscopy & treatment	Y		A2	24.3268	$1,020.24
50561	Kidney endoscopy & treatment	Y		A2	24.3268	$1,020.24
50562	Renal scope w/tumor resect	Y		G2	6.8736	$288.27
50570	Kidney endoscopy	Y		G2	6.8736	$288.27
50572	Kidney endoscopy	Y		G2	6.8736	$288.27
50574	Kidney endoscopy & biopsy	Y		G2	6.8736	$288.27
50575	Kidney endoscopy	Y		G2	34.5115	$1,447.38
50576	Kidney endoscopy & treatment	Y		G2	16.2347	$680.87
50580	Kidney endoscopy & treatment	Y		G2	16.2347	$680.87
50590	Fragmenting of kidney stone	Y		G2	38.7808	$1,626.43
50592	Perc rf ablate renal tumor	Y		G2	52.256	$2,191.56
50593	Perc cryo ablate renal tum	Y	CH	G2	52.256	$2,191.56
50684	Injection for ureter x-ray	N		N1		
50686	Measure ureter pressure	Y		P2	1.0263	$43.04
50688	Change of ureter tube/stent	Y		A2	15.0738	$632.18
50690	Injection for ureter x-ray	N		N1		
50727	Revise ureter	Y		G2	18.5578	$778.30
50947	Laparo new ureter/bladder	Y		A2	44.1995	$1,853.68
50948	Laparo new ureter/bladder	Y		A2	44.1995	$1,853.68
50951	Endoscopy of ureter	Y		A2	6.8736	$288.27
50953	Endoscopy of ureter	Y		A2	6.8736	$288.27

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
50955	Ureter endoscopy & biopsy	Y		A2	24.3268	$1,020.24
50957	Ureter endoscopy & treatment	Y		A2	24.3268	$1,020.24
50961	Ureter endoscopy & treatment	Y		A2	24.3268	$1,020.24
50970	Ureter endoscopy	Y		A2	6.8736	$288.27
50972	Ureter endoscopy & catheter	Y		A2	6.8736	$288.27
50974	Ureter endoscopy & biopsy	Y		A2	16.2347	$680.87
50976	Ureter endoscopy & treatment	Y		A2	16.2347	$680.87
50980	Ureter endoscopy & treatment	Y		A2	24.3268	$1,020.24
51020	Incise & treat bladder	Y		A2	24.3268	$1,020.24
51030	Incise & treat bladder	Y		A2	24.3268	$1,020.24
51040	Incise & drain bladder	Y		A2	24.3268	$1,020.24
51045	Incise bladder/drain ureter	Y		A2	6.8736	$288.27
51050	Removal of bladder stone	Y		A2	24.3268	$1,020.24
51065	Remove ureter calculus	Y		A2	24.3268	$1,020.24
51080	Drainage of bladder abscess	Y		A2	18.6604	$782.60
51100	Drain bladder by needle	Y		P3		$26.03
51101	Drain bladder by trocar/cath	Y		P2	1.0263	$43.04
51102	Drain bl w/cath insertion	Y		A2	18.5578	$778.30
51500	Removal of bladder cyst	Y		A2	30.5585	$1,281.59
51520	Removal of bladder lesion	Y		A2	24.3268	$1,020.24
51535	Repair of ureter lesion	Y		G2	24.3268	$1,020.24
51600	Injection for bladder x-ray	N		N1		
51605	Preparation for bladder xray	N		N1		
51610	Injection for bladder x-ray	N		N1		
51700	Irrigation of bladder	Y		P3		$41.60
51701	Insert bladder catheter	N		P2	0.6201	$26.01
51702	Insert temp bladder cath	N		P2	0.6201	$26.01
51703	Insert bladder cath complex	Y		P2	1.0263	$43.04
51705	Change of bladder tube	Y		P3		$56.40
51710	Change of bladder tube	Y		A2	5.8475	$245.24
51715	Endoscopic injection/implant	Y		A2	30.1718	$1,265.38
51720	Treatment of bladder lesion	Y		P3		$45.17
51725	Simple cystometrogram	Y		P3		$100.30

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
51726	Complex cystometrogram	Y		A2	2.9669	$124.43
51727	Cystometrogram w/up	Y		P2	2.9669	$124.43
51728	Cystometrogram w/vp	Y		P2	2.9669	$124.43
51729	Cystometrogram w/vp&up	Y		P2	2.9669	$124.43
51736	Urine flow measurement	N		P3		$17.10
51741	Electro-uroflowmetry first	Y		P3		$19.91
51784	Anal/urinary muscle study	Y		P2	1.0263	$43.04
51785	Anal/urinary muscle study	Y		A2	1.8817	$78.92
51792	Urinary reflex study	Y		P2	1.0263	$43.04
51797	Intraabdominal pressure test	Y		P3		$69.93
51798	Us urine capacity measure	N		P3		$14.55
51880	Repair of bladder opening	Y		A2	24.3268	$1,020.24
51992	Laparo sling operation	Y		A2	44.1995	$1,853.68
52000	Cystoscopy	Y		A2	6.8736	$288.27
52001	Cystoscopy removal of clots	Y		A2	16.2347	$680.87
52005	Cystoscopy & ureter catheter	Y		A2	24.3268	$1,020.24
52007	Cystoscopy and biopsy	Y		A2	24.3268	$1,020.24
52010	Cystoscopy & duct catheter	Y		A2	6.8736	$288.27
52204	Cystoscopy w/biopsy(s)	Y		A2	24.3268	$1,020.24
52214	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52224	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52234	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52235	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52240	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52250	Cystoscopy and radiotracer	Y		A2	24.3268	$1,020.24
52260	Cystoscopy and treatment	Y		A2	16.2347	$680.87
52265	Cystoscopy and treatment	Y		P3		$228.42
52270	Cystoscopy & revise urethra	Y		A2	16.2347	$680.87
52275	Cystoscopy & revise urethra	Y		A2	24.3268	$1,020.24
52276	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52277	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52281	Cystoscopy and treatment	Y		A2	16.2347	$680.87
52282	Cystoscopy implant stent	Y		A2	34.5115	$1,447.38
52283	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52285	Cystoscopy and treatment	Y		A2	16.2347	$680.87
52290	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
52300	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52301	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52305	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52310	Cystoscopy and treatment	Y		A2	16.2347	$680.87
52315	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52317	Remove bladder stone	Y		A2	24.3268	$1,020.24
52318	Remove bladder stone	Y		A2	24.3268	$1,020.24
52320	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52325	Cystoscopy stone removal	Y		A2	24.3268	$1,020.24
52327	Cystoscopy inject material	Y		A2	34.5115	$1,447.38
52330	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52332	Cystoscopy and treatment	Y		A2	24.3268	$1,020.24
52334	Create passage to kidney	Y		A2	24.3268	$1,020.24
52341	Cysto w/ureter stricture tx	Y		A2	24.3268	$1,020.24
52342	Cysto w/up stricture tx	Y		A2	24.3268	$1,020.24
52343	Cysto w/renal stricture tx	Y		A2	24.3268	$1,020.24
52344	Cysto/uretero stricture tx	Y		A2	24.3268	$1,020.24
52345	Cysto/uretero w/up stricture	Y		A2	24.3268	$1,020.24
52346	Cystouretero w/renal strict	Y		A2	24.3268	$1,020.24
52351	Cystouretero & or pyeloscope	Y		A2	24.3268	$1,020.24
52352	Cystouretero w/stone remove	Y		A2	24.3268	$1,020.24
52353	Cystouretero w/lithotripsy	Y		A2	34.5115	$1,447.38
52354	Cystouretero w/biopsy	Y		A2	24.3268	$1,020.24
52355	Cystouretero w/excise tumor	Y		A2	24.3268	$1,020.24
52400	Cystouretero w/congen repr	Y		A2	24.3268	$1,020.24
52402	Cystourethro cut ejacul duct	Y		A2	24.3268	$1,020.24
52450	Incision of prostate	Y		A2	24.3268	$1,020.24
52500	Revision of bladder neck	Y		A2	24.3268	$1,020.24
52601	Prostatectomy (TURP)	Y		A2	34.5115	$1,447.38
52630	Remove prostate regrowth	Y		A2	34.5115	$1,447.38
52640	Relieve bladder contracture	Y		A2	24.3268	$1,020.24
52647	Laser surgery of prostate	Y		A2	42.9298	$1,800.43
52648	Laser surgery of prostate	Y		A2	42.9298	$1,800.43
52649	Prostate laser enucleation	Y	CH	G2	42.9298	$1,800.43
52700	Drainage of prostate abscess	Y		A2	24.3268	$1,020.24
53000	Incision of urethra	Y		A2	20.0393	$840.43

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
53010	Incision of urethra	Y		A2	20.0393	$840.43
53020	Incision of urethra	Y		A2	20.0393	$840.43
53025	Incision of urethra	Y		R2	20.0393	$840.43
53040	Drainage of urethra abscess	Y		A2	20.0393	$840.43
53060	Drainage of urethra abscess	Y		P3		$62.53
53080	Drainage of urinary leakage	Y		A2	20.0393	$840.43
53085	Drainage of urinary leakage	Y		G2	20.0393	$840.43
53200	Biopsy of urethra	Y		A2	20.0393	$840.43
53210	Removal of urethra	Y		A2	30.1718	$1,265.38
53215	Removal of urethra	Y		A2	20.0393	$840.43
53220	Treatment of urethra lesion	Y		A2	30.1718	$1,265.38
53230	Removal of urethra lesion	Y		A2	30.1718	$1,265.38
53235	Removal of urethra lesion	Y		A2	20.0393	$840.43
53240	Surgery for urethra pouch	Y		A2	30.1718	$1,265.38
53250	Removal of urethra gland	Y		A2	20.0393	$840.43
53260	Treatment of urethra lesion	Y		A2	20.0393	$840.43
53265	Treatment of urethra lesion	Y		A2	20.0393	$840.43
53270	Removal of urethra gland	Y		A2	20.0393	$840.43
53275	Repair of urethra defect	Y		A2	20.0393	$840.43
53400	Revise urethra stage 1	Y		A2	30.1718	$1,265.38
53405	Revise urethra stage 2	Y		A2	30.1718	$1,265.38
53410	Reconstruction of urethra	Y		A2	30.1718	$1,265.38
53420	Reconstruct urethra stage 1	Y		A2	30.1718	$1,265.38
53425	Reconstruct urethra stage 2	Y		A2	30.1718	$1,265.38
53430	Reconstruction of urethra	Y		A2	30.1718	$1,265.38
53431	Reconstruct urethra/bladder	Y		A2	30.1718	$1,265.38
53440	Male sling procedure	N		H8	139.5586	$5,852.95
53442	Remove/revise male sling	Y		A2	30.1718	$1,265.38
53444	Insert tandem cuff	N		H8	139.5586	$5,852.95
53445	Insert uro/ves nck sphincter	N		H8	242.6169	$10,175.11
53446	Remove uro sphincter	Y		A2	30.1718	$1,265.38
53447	Remove/replace ur sphincter	N		H8	242.6169	$10,175.11
53449	Repair uro sphincter	Y		A2	30.1718	$1,265.38
53450	Revision of urethra	Y		A2	30.1718	$1,265.38
53460	Revision of urethra	Y		A2	20.0393	$840.43
53502	Repair of urethra injury	Y		A2	20.0393	$840.43

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
53505	Repair of urethra injury	Y		A2	30.1718	$1,265.38
53510	Repair of urethra injury	Y		A2	20.0393	$840.43
53515	Repair of urethra injury	Y		A2	30.1718	$1,265.38
53520	Repair of urethra defect	Y		A2	30.1718	$1,265.38
53600	Dilate urethra stricture	Y		P3		$31.90
53601	Dilate urethra stricture	Y		P3		$37.01
53605	Dilate urethra stricture	Y		A2	16.2347	$680.87
53620	Dilate urethra stricture	Y		P3		$47.98
53621	Dilate urethra stricture	Y		P3		$50.53
53660	Dilation of urethra	Y		P3		$36.24
53661	Dilation of urethra	Y		P3		$35.22
53665	Dilation of urethra	Y		A2	20.0393	$840.43
53850	Prostatic microwave thermotx	Y		P3		$1,491.74
53852	Prostatic rf thermotx	Y		P3		$1,407.01
53855	Insert prost urethral stent	Y		P2	1.8817	$78.92
53860	Transurethral rf treatment	Y	NI	G2	18.5578	$778.30
54000	Slitting of prepuce	Y		A2	20.0393	$840.43
54001	Slitting of prepuce	Y		A2	20.0393	$840.43
54015	Drain penis lesion	Y		A2	18.6604	$782.60
54050	Destruction penis lesion(s)	Y		P2	0.8409	$35.27
54055	Destruction penis lesion(s)	Y		P3		$55.38
54056	Cryosurgery penis lesion(s)	Y		P2	0.8409	$35.27
54057	Laser surg penis lesion(s)	Y		A2	20.136	$844.48
54060	Excision of penis lesion(s)	Y		A2	20.136	$844.48
54065	Destruction penis lesion(s)	Y		A2	20.136	$844.48
54100	Biopsy of penis	Y		A2	16.7008	$700.41
54105	Biopsy of penis	Y		A2	22.0775	$925.91
54110	Treatment of penis lesion	Y		A2	33.2073	$1,392.68
54111	Treat penis lesion graft	Y		A2	33.2073	$1,392.68
54112	Treat penis lesion graft	Y		A2	33.2073	$1,392.68
54115	Treatment of penis lesion	Y		A2	18.6604	$782.60
54120	Partial removal of penis	Y		A2	33.2073	$1,392.68
54150	Circumcision w/regionl block	Y		A2	21.9272	$919.60
54160	Circumcision neonate	Y		A2	21.9272	$919.60
54161	Circum 28 days or older	Y		A2	21.9272	$919.60
54162	Lysis penil circumic lesion	Y		A2	21.9272	$919.60

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54163	Repair of circumcision	Y		A2	21.9272	$919.60
54164	Frenulotomy of penis	Y		A2	21.9272	$919.60
54200	Treatment of penis lesion	Y		P3		$54.11
54205	Treatment of penis lesion	Y		A2	33.2073	$1,392.68
54220	Treatment of penis lesion	Y		A2	1.8817	$78.92
54230	Prepare penis study	N		N1		
54231	Dynamic cavernosometry	Y		P3		$52.06
54235	Penile injection	Y		P3		$37.01
54240	Penis study	Y		P3		$26.29
54250	Penis study	Y		P3		$8.68
54300	Revision of penis	Y		A2	33.2073	$1,392.68
54304	Revision of penis	Y		A2	33.2073	$1,392.68
54308	Reconstruction of urethra	Y		A2	33.2073	$1,392.68
54312	Reconstruction of urethra	Y		A2	33.2073	$1,392.68
54316	Reconstruction of urethra	Y		A2	33.2073	$1,392.68
54318	Reconstruction of urethra	Y		A2	33.2073	$1,392.68
54322	Reconstruction of urethra	Y		A2	33.2073	$1,392.68
54324	Reconstruction of urethra	Y		A2	33.2073	$1,392.68
54326	Reconstruction of urethra	Y		A2	33.2073	$1,392.68
54328	Revise penis/urethra	Y		A2	33.2073	$1,392.68
54340	Secondary urethral surgery	Y		A2	33.2073	$1,392.68
54344	Secondary urethral surgery	Y		A2	33.2073	$1,392.68
54348	Secondary urethral surgery	Y		A2	33.2073	$1,392.68
54352	Reconstruct urethra/penis	Y		A2	33.2073	$1,392.68
54360	Penis plastic surgery	Y		A2	33.2073	$1,392.68
54380	Repair penis	Y		A2	33.2073	$1,392.68
54385	Repair penis	Y		A2	33.2073	$1,392.68
54400	Insert semi-rigid prosthesis	N		H8	139.5586	$5,852.95
54401	Insert self-contd prosthesis	N		H8	242.6169	$10,175.11
54405	Insert multi-comp penis pros	N		H8	242.6169	$10,175.11
54406	Remove muti-comp penis pros	Y		A2	33.2073	$1,392.68
54408	Repair multi-comp penis pros	Y		A2	33.2073	$1,392.68
54410	Remove/replace penis prosth	N		H8	242.6169	$10,175.11
54415	Remove self-contd penis pros	Y		A2	33.2073	$1,392.68
54416	Remv/repl penis contain pros	N		H8	242.6169	$10,175.11
54420	Revision of penis	Y		A2	33.2073	$1,392.68

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54435	Revision of penis	Y		A2	33.2073	$1,392.68
54440	Repair of penis	Y		A2	33.2073	$1,392.68
54450	Preputial stretching	Y		A2	2.9669	$124.43
54500	Biopsy of testis	Y		A2	14.5045	$608.30
54505	Biopsy of testis	Y		A2	21.9272	$919.60
54512	Excise lesion testis	Y		A2	21.9272	$919.60
54520	Removal of testis	Y		A2	21.9272	$919.60
54522	Orchiectomy partial	Y		A2	21.9272	$919.60
54530	Removal of testis	Y		A2	30.5585	$1,281.59
54550	Exploration for testis	Y		A2	30.5585	$1,281.59
54560	Exploration for testis	Y		G2	21.9272	$919.60
54600	Reduce testis torsion	Y		A2	21.9272	$919.60
54620	Suspension of testis	Y		A2	21.9272	$919.60
54640	Suspension of testis	Y		A2	30.5585	$1,281.59
54660	Revision of testis	Y		A2	21.9272	$919.60
54670	Repair testis injury	Y		A2	21.9272	$919.60
54680	Relocation of testis(es)	Y		A2	21.9272	$919.60
54690	Laparoscopy orchiectomy	Y		A2	44.1995	$1,853.68
54692	Laparoscopy orchiopexy	Y		G2	65.6803	$2,754.57
54700	Drainage of scrotum	Y		A2	21.9272	$919.60
54800	Biopsy of epididymis	Y		A2	4.235	$177.61
54830	Remove epididymis lesion	Y		A2	21.9272	$919.60
54840	Remove epididymis lesion	Y		A2	21.9272	$919.60
54860	Removal of epididymis	Y		A2	21.9272	$919.60
54861	Removal of epididymis	Y		A2	21.9272	$919.60
54865	Explore epididymis	Y		A2	21.9272	$919.60
54900	Fusion of spermatic ducts	Y		A2	21.9272	$919.60
54901	Fusion of spermatic ducts	Y		A2	21.9272	$919.60
55000	Drainage of hydrocele	Y		P3		$52.83
55040	Removal of hydrocele	Y		A2	30.5585	$1,281.59
55041	Removal of hydroceles	Y		A2	30.5585	$1,281.59
55060	Repair of hydrocele	Y		A2	21.9272	$919.60
55100	Drainage of scrotum abscess	Y		A2	12.0213	$504.16
55110	Explore scrotum	Y		A2	21.9272	$919.60
55120	Removal of scrotum lesion	Y		A2	21.9272	$919.60
55150	Removal of scrotum	Y		A2	21.9272	$919.60

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55175	Revision of scrotum	Y		A2	21.9272	$919.60
55180	Revision of scrotum	Y		A2	21.9272	$919.60
55200	Incision of sperm duct	Y		A2	21.9272	$919.60
55250	Removal of sperm duct(s)	Y		A2	21.9272	$919.60
55300	Prepare sperm duct x-ray	N		N1		
55400	Repair of sperm duct	Y		A2	21.9272	$919.60
55450	Ligation of sperm duct	Y		P3		$165.38
55500	Removal of hydrocele	Y		A2	21.9272	$919.60
55520	Removal of sperm cord lesion	Y		A2	21.9272	$919.60
55530	Revise spermatic cord veins	Y		A2	21.9272	$919.60
55535	Revise spermatic cord veins	Y		A2	30.5585	$1,281.59
55540	Revise hernia & sperm veins	Y		A2	30.5585	$1,281.59
55550	Laparo ligate spermatic vein	Y		A2	44.1995	$1,853.68
55600	Incise sperm duct pouch	Y		R2	21.9272	$919.60
55680	Remove sperm pouch lesion	Y		A2	21.9272	$919.60
55700	Biopsy of prostate	Y		A2	12.0358	$504.77
55705	Biopsy of prostate	Y		A2	12.0358	$504.77
55706	Prostate saturation sampling	Y		G2	12.0358	$504.77
55720	Drainage of prostate abscess	Y		A2	24.3268	$1,020.24
55725	Drainage of prostate abscess	Y		A2	24.3268	$1,020.24
55860	Surgical exposure prostate	Y		G2	18.5578	$778.30
55870	Electroejaculation	Y		P3		$64.31
55873	Cryoablate prostate	Y		H8	156.4508	$6,561.39
55875	Transperi needle place pros	N		A2	34.5115	$1,447.38
55876	Place rt device/marker pros	N		P3		$57.93
55920	Place needles pelvic for rt	Y		G2	24.4649	$1,026.03
56405	I & D of vulva/perineum	Y		P3		$38.28
56420	Drainage of gland abscess	Y		P3		$50.79
56440	Surgery for vulva lesion	Y		A2	19.1022	$801.13
56441	Lysis of labial lesion(s)	Y		A2	19.1022	$801.13
56442	Hymenotomy	Y		A2	19.1022	$801.13
56501	Destroy vulva lesions sim	Y		P3		$51.81
56515	Destroy vulva lesion/s compl	Y		A2	20.136	$844.48
56605	Biopsy of vulva/perineum	Y		P3		$29.86
56606	Biopsy of vulva/perineum	Y		P3		$12.25
56620	Partial removal of vulva	Y		A2	19.1022	$801.13

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
56625	Complete removal of vulva	Y		A2	19.1022	$801.13
56700	Partial removal of hymen	Y		A2	19.1022	$801.13
56740	Remove vagina gland lesion	Y		A2	19.1022	$801.13
56800	Repair of vagina	Y		A2	19.1022	$801.13
56805	Repair clitoris	Y		G2	19.1022	$801.13
56810	Repair of perineum	Y		A2	19.1022	$801.13
56820	Exam of vulva w/scope	Y		P3		$38.79
56821	Exam/biopsy of vulva w/scope	Y		P3		$50.28
57000	Exploration of vagina	Y		A2	19.1022	$801.13
57010	Drainage of pelvic abscess	Y		A2	19.1022	$801.13
57020	Drainage of pelvic fluid	Y		A2	6.0657	$254.39
57022	I & d vaginal hematoma pp	Y		R2	12.0213	$504.16
57023	I & d vag hematoma non-ob	Y		A2	18.6604	$782.60
57061	Destroy vag lesions simple	Y		P3		$47.47
57065	Destroy vag lesions complex	Y		A2	19.1022	$801.13
57100	Biopsy of vagina	Y		P3		$30.88
57105	Biopsy of vagina	Y		A2	19.1022	$801.13
57130	Remove vagina lesion	Y		A2	19.1022	$801.13
57135	Remove vagina lesion	Y		A2	19.1022	$801.13
57150	Treat vagina infection	Y		P3		$20.16
57155	Insert uteri tandems/ovoids	Y		A2	6.0657	$254.39
57156	Ins vag brachytx device	Y	NI	G2	3.3445	$140.26
57160	Insert pessary/other device	Y		P3		$31.65
57170	Fitting of diaphragm/cap	Y		P2	0.1336	$5.60
57180	Treat vaginal bleeding	Y		A2	1.5104	$63.34
57200	Repair of vagina	Y		A2	19.1022	$801.13
57210	Repair vagina/perineum	Y		A2	19.1022	$801.13
57220	Revision of urethra	Y		A2	41.9348	$1,758.70
57230	Repair of urethral lesion	Y		A2	32.9555	$1,382.12
57240	Repair bladder & vagina	Y		A2	32.9555	$1,382.12
57250	Repair rectum & vagina	Y		A2	32.9555	$1,382.12
57260	Repair of vagina	Y		A2	32.9555	$1,382.12
57265	Extensive repair of vagina	Y		A2	41.9348	$1,758.70
57267	Insert mesh/pelvic flr addon	Y		A2	32.9555	$1,382.12
57268	Repair of bowel bulge	Y		A2	32.9555	$1,382.12
57287	Revise/remove sling repair	Y		G2	32.9555	$1,382.12

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
57288	Repair bladder defect	Y		A2	41.9348	$1,758.70
57289	Repair bladder & vagina	Y		A2	32.9555	$1,382.12
57291	Construction of vagina	Y		A2	32.9555	$1,382.12
57295	Revise vag graft via vagina	Y		G2	19.1022	$801.13
57300	Repair rectum-vagina fistula	Y		A2	32.9555	$1,382.12
57320	Repair bladder-vagina lesion	Y		G2	32.9555	$1,382.12
57400	Dilation of vagina	Y		A2	19.1022	$801.13
57410	Pelvic examination	Y		A2	19.1022	$801.13
57415	Remove vaginal foreign body	Y		A2	19.1022	$801.13
57420	Exam of vagina w/scope	Y		P3		$40.07
57421	Exam/biopsy of vag w/scope	Y		P3		$52.32
57426	Revise prosth vag graft lap	Y		G2	19.1022	$801.13
57452	Exam of cervix w/scope	Y		P3		$37.77
57454	Bx/curett of cervix w/scope	Y		P3		$46.96
57455	Biopsy of cervix w/scope	Y		P3		$49.00
57456	Endocerv curettage w/scope	Y		P3		$47.22
57460	Bx of cervix w/scope leep	Y		P3		$135.78
57461	Conz of cervix w/scope leep	Y		P3		$145.47
57500	Biopsy of cervix	Y		P3		$62.78
57505	Endocervical curettage	Y		P3		$41.60
57510	Cauterization of cervix	Y		P3		$43.39
57511	Cryocautery of cervix	Y		P3		$52.06
57513	Laser surgery of cervix	Y		A2	19.1022	$801.13
57520	Conization of cervix	Y		A2	19.1022	$801.13
57522	Conization of cervix	Y		A2	19.1022	$801.13
57530	Removal of cervix	Y		A2	32.9555	$1,382.12
57550	Removal of residual cervix	Y		A2	32.9555	$1,382.12
57556	Remove cervix repair bowel	Y		A2	41.9348	$1,758.70
57558	D&c of cervical stump	Y		A2	19.1022	$801.13
57700	Revision of cervix	Y		A2	19.1022	$801.13
57720	Revision of cervix	Y		A2	19.1022	$801.13
57800	Dilation of cervical canal	Y		P3		$22.71
58100	Biopsy of uterus lining	Y		P3		$37.52
58110	Bx done w/colposcopy add-on	N		N1		
58120	Dilation and curettage	Y		A2	19.1022	$801.13
58145	Myomectomy vag method	Y		A2	32.9555	$1,382.12

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58301	Remove intrauterine device	Y		P3		$34.45
58321	Artificial insemination	Y		P3		$31.65
58322	Artificial insemination	Y		P3		$32.92
58323	Sperm washing	Y		P3		$6.38
58340	Catheter for hysterography	N		N1		
58345	Reopen fallopian tube	Y		R2	19.1022	$801.13
58346	Insert heyman uteri capsule	Y		A2	19.1022	$801.13
58350	Reopen fallopian tube	Y		A2	32.9555	$1,382.12
58353	Endometr ablate thermal	Y		A2	32.9555	$1,382.12
58356	Endometrial cryoablation	Y		P3		$1,320.24
58545	Laparoscopic myomectomy	Y		A2	35.7062	$1,497.48
58546	Laparo-myomectomy complex	Y		A2	44.1995	$1,853.68
58550	Laparo-asst vag hysterectomy	Y		A2	65.6803	$2,754.57
58552	Laparo-vag hyst incl t/o	Y		G2	44.1995	$1,853.68
58555	Hysteroscopy dx sep proc	Y		A2	21.324	$894.31
58558	Hysteroscopy biopsy	Y		A2	21.324	$894.31
58559	Hysteroscopy lysis	Y		A2	21.324	$894.31
58560	Hysteroscopy resect septum	Y		A2	35.5608	$1,491.38
58561	Hysteroscopy remove myoma	Y		A2	35.5608	$1,491.38
58562	Hysteroscopy remove fb	Y		A2	21.324	$894.31
58563	Hysteroscopy ablation	Y		A2	35.5608	$1,491.38
58565	Hysteroscopy sterilization	Y		A2	41.9348	$1,758.70
58600	Division of fallopian tube	Y		G2	32.9555	$1,382.12
58615	Occlude fallopian tube(s)	Y		G2	19.1022	$801.13
58660	Laparoscopy lysis	Y		A2	44.1995	$1,853.68
58661	Laparoscopy remove adnexa	Y		A2	44.1995	$1,853.68
58662	Laparoscopy excise lesions	Y		A2	44.1995	$1,853.68
58670	Laparoscopy tubal cautery	Y		A2	44.1995	$1,853.68
58671	Laparoscopy tubal block	Y		A2	44.1995	$1,853.68
58672	Laparoscopy fimbrioplasty	Y		A2	44.1995	$1,853.68
58673	Laparoscopy salpingostomy	Y		A2	44.1995	$1,853.68
58800	Drainage of ovarian cyst(s)	Y		A2	19.1022	$801.13
58805	Drainage of ovarian cyst(s)	Y		G2	32.9555	$1,382.12
58820	Drain ovary abscess open	Y		A2	32.9555	$1,382.12
58900	Biopsy of ovary(s)	Y		A2	19.1022	$801.13

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58970	Retrieval of oocyte	Y		A2	3.3445	$140.26
58974	Transfer of embryo	Y		A2	3.3445	$140.26
58976	Transfer of embryo	Y		A2	3.3445	$140.26
59000	Amniocentesis diagnostic	Y		P3		$54.36
59001	Amniocentesis therapeutic	Y		R2	6.0657	$254.39
59012	Fetal cord puncture prenatal	Y		G2	3.3445	$140.26
59015	Chorion biopsy	Y		P3		$46.96
59020	Fetal contract stress test	Y		P3		$23.99
59025	Fetal non-stress test	Y		P3		$12.76
59070	Transabdom amnioinfus w/us	Y		G2	1.5104	$63.34
59072	Umbilical cord occlud w/us	Y		G2	3.3445	$140.26
59076	Fetal shunt placement w/us	Y		G2	3.3445	$140.26
59100	Remove uterus lesion	Y		R2	32.9555	$1,382.12
59150	Treat ectopic pregnancy	Y		G2	44.1995	$1,853.68
59151	Treat ectopic pregnancy	Y		G2	44.1995	$1,853.68
59160	D & c after delivery	Y		A2	19.1022	$801.13
59200	Insert cervical dilator	Y		P3		$29.86
59300	Episiotomy or vaginal repair	Y		P3		$67.63
59320	Revision of cervix	Y		A2	19.1022	$801.13
59412	Antepartum manipulation	Y		G2	19.1022	$801.13
59414	Deliver placenta	Y		G2	19.1022	$801.13
59812	Treatment of miscarriage	Y		A2	19.1022	$801.13
59820	Care of miscarriage	Y		A2	19.1022	$801.13
59821	Treatment of miscarriage	Y		A2	19.1022	$801.13
59840	Abortion	Y		A2	19.1022	$801.13
59841	Abortion	Y		A2	19.1022	$801.13
59866	Abortion (mpr)	Y		G2	3.3445	$140.26
59870	Evacuate mole of uterus	Y		A2	19.1022	$801.13
59871	Remove cerclage suture	Y		A2	19.1022	$801.13
60000	Drain thyroid/tongue cyst	Y		A2	7.3159	$306.82
60100	Biopsy of thyroid	Y		P3		$40.58
60200	Remove thyroid lesion	Y		A2	46.9119	$1,967.44
60210	Partial thyroid excision	Y		G2	46.9119	$1,967.44
60212	Partial thyroid excision	Y		G2	46.9119	$1,967.44
60220	Partial removal of thyroid	Y		G2	46.9119	$1,967.44
60225	Partial removal of thyroid	Y		G2	46.9119	$1,967.44

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60280	Remove thyroid duct lesion	Y		A2	46.9119	$1,967.44
60281	Remove thyroid duct lesion	Y		A2	46.9119	$1,967.44
60300	Aspir/inj thyroid cyst	Y		P3		$56.15
61000	Remove cranial cavity fluid	Y		R2	7.0103	$294.00
61001	Remove cranial cavity fluid	Y		R2	7.0103	$294.00
61020	Remove brain cavity fluid	Y		A2	7.0103	$294.00
61026	Injection into brain canal	Y		A2	7.0103	$294.00
61050	Remove brain canal fluid	Y		A2	7.0103	$294.00
61055	Injection into brain canal	Y		A2	7.0103	$294.00
61070	Brain canal shunt procedure	Y		A2	5.8475	$245.24
61215	Insert brain-fluid device	Y		A2	38.7226	$1,623.99
61330	Decompress eye socket	Y		G2	41.2845	$1,731.43
61334	Explore orbit/remove object	Y		G2	41.2845	$1,731.43
61770	Incise skull for treatment	Y		G2	34.4344	$1,444.14
61781	Scan proc cranial intra	N	NI	N1		
61782	Scan proc cranial extra	N	NI	N1		
61783	Scan proc spinal	N	NI	N1		
61790	Treat trigeminal nerve	Y		A2	17.6746	$741.26
61791	Treat trigeminal tract	Y		A2	11.8201	$495.72
61795	Brain surgery using computer	N	CH	D5		
61880	Revise/remove neuroelectrode	Y		G2	20.0672	$841.60
61885	Insrt/redo neurostim 1 array	N		H8	329.4318	$13,816.04
61886	Implant neurostim arrays	N		H8	425.6081	$17,849.58
61888	Revise/remove neuroreceiver	Y		A2	26.8696	$1,126.88
62160	Neuroendoscopy add-on	N		N1		
62194	Replace/irrigate catheter	Y		A2	7.0103	$294.00
62225	Replace/irrigate catheter	Y		A2	15.0738	$632.18
62230	Replace/revise brain shunt	Y		A2	38.7226	$1,623.99
62252	Csf shunt reprogram	N		P3		$33.94
62263	Epidural lysis mult sessions	Y		A2	7.0103	$294.00
62264	Epidural lysis on single day	Y		A2	11.8201	$495.72
62267	Interdiscal perq aspir dx	Y		G2	4.235	$177.61
62268	Drain spinal cord cyst	Y		A2	7.0103	$294.00
62269	Needle biopsy spinal cord	Y		A2	8.9935	$377.18
62270	Spinal fluid tap diagnostic	Y		A2	3.5865	$150.41
62272	Drain cerebro spinal fluid	Y		A2	3.5865	$150.41

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62273	Inject epidural patch	Y		A2	7.0103	$294.00
62280	Treat spinal cord lesion	Y		A2	7.0103	$294.00
62281	Treat spinal cord lesion	Y		A2	7.0103	$294.00
62282	Treat spinal canal lesion	Y		A2	7.0103	$294.00
62284	Injection for myelogram	N		N1		
62287	Percutaneous diskectomy	Y		A2	34.4344	$1,444.14
62290	Inject for spine disk x-ray	N		N1		
62291	Inject for spine disk x-ray	N		N1		
62292	Injection into disk lesion	Y		R2	7.0103	$294.00
62294	Injection into spinal artery	Y		A2	7.0103	$294.00
62310	Inject spine c/t	Y		A2	7.0103	$294.00
62311	Inject spine l/s (cd)	Y		A2	7.0103	$294.00
62318	Inject spine w/cath c/t	Y		A2	7.0103	$294.00
62319	Inject spine w/cath l/s (cd)	Y		A2	11.8201	$495.72
62350	Implant spinal canal cath	Y		A2	38.7226	$1,623.99
62355	Remove spinal canal catheter	Y		A2	11.8201	$495.72
62360	Insert spine infusion device	Y		A2	38.7226	$1,623.99
62361	Implant spine infusion pump	Y		H8	291.4063	$12,221.29
62362	Implant spine infusion pump	Y		H8	291.4063	$12,221.29
62365	Remove spine infusion device	Y		A2	34.4344	$1,444.14
62367	Analyze spine infusion pump	N		P3		$16.84
62368	Analyze spine infusion pump	N		P3		$22.46
63600	Remove spinal cord lesion	Y		A2	17.6746	$741.26
63610	Stimulation of spinal cord	Y		A2	17.6746	$741.26
63615	Remove lesion of spinal cord	Y		R2	17.6746	$741.26
63650	Implant neuroelectrodes	N		H8	88.401	$3,707.45
63655	Implant neuroelectrodes	N		J8	124.554	$5,223.67
63661	Remove spine eltrd perq aray	Y		G2	20.0672	$841.60
63662	Remove spine eltrd plate	Y		G2	20.0672	$841.60
63663	Revise spine eltrd perq aray	Y		G2	20.0672	$841.60
63664	Revise spine eltrd plate	Y		G2	20.0672	$841.60
63685	Insrt/redo spine n generator	N		H8	329.4318	$13,816.04
63688	Revise/remove neuroreceiver	Y		A2	26.8696	$1,126.88
63744	Revision of spinal shunt	Y		A2	38.7226	$1,623.99
63746	Removal of spinal shunt	Y		A2	11.8201	$495.72
64400	N block inj trigeminal	Y		P3		$52.06

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64402	N block inj facial	Y		P3		$48.24
64405	N block inj occipital	Y		P3		$44.41
64408	N block inj vagus	Y		P3		$52.32
64410	N block inj phrenic	Y		A2	7.0103	$294.00
64412	N block inj spinal accessor	Y		P3		$77.08
64413	N block inj cervical plexus	Y		P3		$48.49
64415	N block inj brachial plexus	Y		A2	3.5865	$150.41
64416	N block cont infuse b plex	Y		G2	7.0103	$294.00
64417	N block inj axillary	Y		A2	3.5865	$150.41
64418	N block inj suprascapular	Y		P3		$66.36
64420	N block inj intercost sng	Y		A2	3.5865	$150.41
64421	N block inj intercost mlt	Y		A2	7.0103	$294.00
64425	N block inj ilio-ing/hypogi	Y		P3		$48.49
64430	N block inj pudendal	Y		A2	7.0103	$294.00
64435	N block inj paracervical	Y		P3		$63.29
64445	N block inj sciatic sng	Y		P3		$58.70
64446	N blk inj sciatic cont inf	Y		G2	7.0103	$294.00
64447	N block inj fem single	Y		P3		$48.49
64448	N block inj fem cont inf	Y		G2	7.0103	$294.00
64449	N block inj lumbar plexus	Y		G2	7.0103	$294.00
64450	N block other peripheral	Y		P3		$41.60
64455	N block inj plantar digit	Y		P3		$15.57
64479	Inj foramen epidural c/t	Y		A2	7.0103	$294.00
64480	Inj foramen epidural add-on	Y		A2	3.5865	$150.41
64483	Inj foramen epidural l/s	Y		A2	7.0103	$294.00
64484	Inj foramen epidural add-on	Y		A2	3.5865	$150.41
64490	Inj paravert f jnt c/t 1 lev	Y		G2	7.0103	$294.00
64491	Inj paravert f jnt c/t 2 lev	Y		G2	2.465	$103.38
64492	Inj paravert f jnt c/t 3 lev	Y		G2	2.465	$103.38
64493	Inj paravert f jnt l/s 1 lev	Y		G2	7.0103	$294.00
64494	Inj paravert f jnt l/s 2 lev	Y		G2	2.465	$103.38
64495	Inj paravert f jnt l/s 3 lev	Y		G2	2.465	$103.38
64505	N block spenopalatine gangl	Y		P3		$36.50
64508	N block carotid sinus s/p	Y		P3		$43.90
64510	N block stellate ganglion	Y		A2	7.0103	$294.00
64517	N block inj hypogas plxs	Y		A2	7.0103	$294.00

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64520	N block lumbar/thoracic	Y		A2	7.0103	$294.00
64530	N block inj celiac pelus	Y		A2	7.0103	$294.00
64553	Implant neuroelectrodes	N		H8	88.401	$3,707.45
64555	Implant neuroelectrodes	N		J8	88.401	$3,707.45
64560	Implant neuroelectrodes	N		J8	88.401	$3,707.45
64561	Implant neuroelectrodes	N		H8	88.401	$3,707.45
64565	Implant neuroelectrodes	N		J8	88.401	$3,707.45
64566	Neuroeltrd stim post tibial	Y	NI	G2	2.465	$103.38
64568	Inc for vagus n elect impl	N	NI	J8	508.6874	$21,333.84
64569	Revise/repl vagus n eltrd	Y	NI	G2	20.0672	$841.60
64570	Remove vagus n eltrd	Y	NI	G2	34.4344	$1,444.14
64573	Implant neuroelectrodes	N	CH	D5		
64575	Implant neuroelectrodes	N		H8	124.554	$5,223.67
64577	Implant neuroelectrodes	N		H8	124.554	$5,223.67
64580	Implant neuroelectrodes	N		H8	124.554	$5,223.67
64581	Implant neuroelectrodes	N		H8	124.554	$5,223.67
64585	Revise/remove neuroelectrode	Y		A2	20.0672	$841.60
64590	Insrt/redo pn/gastr stimul	N		H8	329.4318	$13,816.04
64595	Revise/rmv pn/gastr stimul	Y		A2	26.8696	$1,126.88
64600	Injection treatment of nerve	Y		A2	11.8201	$495.72
64605	Injection treatment of nerve	Y		A2	17.6746	$741.26
64610	Injection treatment of nerve	Y		A2	17.6746	$741.26
64611	Chemodenerv saliv glands	Y	NI	P3		$41.86
64612	Destroy nerve face muscle	Y		P3		$61.00
64613	Destroy nerve neck muscle	Y		P3		$57.17
64614	Destroy nerve extrem musc	Y		P3		$64.83
64620	Injection treatment of nerve	Y		A2	7.0103	$294.00
64622	Destr paravertebrl nerve l/s	Y		A2	11.8201	$495.72
64623	Destr paravertebral n add-on	Y		A2	7.0103	$294.00
64626	Destr paravertebrl nerve c/t	Y		A2	7.0103	$294.00
64627	Destr paravertebral n add-on	Y		A2	2.465	$103.38
64630	Injection treatment of nerve	Y		A2	7.0103	$294.00
64632	N block inj common digit	Y		P3		$29.86
64640	Injection treatment of nerve	Y		P3		$86.01
64650	Chemodenerv eccrine glands	Y		P3		$48.49
64653	Chemodenerv eccrine glands	Y		P3		$54.11

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
64680	Injection treatment of nerve	Y		A2	7.0103	$294.00
64681	Injection treatment of nerve	Y		A2	11.8201	$495.72
64702	Revise finger/toe nerve	Y		A2	17.6746	$741.26
64704	Revise hand/foot nerve	Y		A2	17.6746	$741.26
64708	Revise arm/leg nerve	Y		A2	17.6746	$741.26
64712	Revision of sciatic nerve	Y		A2	17.6746	$741.26
64713	Revision of arm nerve(s)	Y		A2	17.6746	$741.26
64714	Revise low back nerve(s)	Y		A2	17.6746	$741.26
64716	Revision of cranial nerve	Y		A2	17.6746	$741.26
64718	Revise ulnar nerve at elbow	Y		A2	17.6746	$741.26
64719	Revise ulnar nerve at wrist	Y		A2	17.6746	$741.26
64721	Carpal tunnel surgery	Y		A2	17.6746	$741.26
64722	Relieve pressure on nerve(s)	Y		A2	17.6746	$741.26
64726	Release foot/toe nerve	Y		A2	17.6746	$741.26
64727	Internal nerve revision	Y		A2	17.6746	$741.26
64732	Incision of brow nerve	Y		A2	17.6746	$741.26
64734	Incision of cheek nerve	Y		A2	17.6746	$741.26
64736	Incision of chin nerve	Y		A2	17.6746	$741.26
64738	Incision of jaw nerve	Y		A2	17.6746	$741.26
64740	Incision of tongue nerve	Y		A2	17.6746	$741.26
64742	Incision of facial nerve	Y		A2	17.6746	$741.26
64744	Incise nerve back of head	Y		A2	17.6746	$741.26
64746	Incise diaphragm nerve	Y		A2	17.6746	$741.26
64761	Incision of pelvis nerve	Y		G2	17.6746	$741.26
64763	Incise hip/thigh nerve	Y		G2	17.6746	$741.26
64766	Incise hip/thigh nerve	Y		G2	34.4344	$1,444.14
64771	Sever cranial nerve	Y		A2	17.6746	$741.26
64772	Incision of spinal nerve	Y		A2	17.6746	$741.26
64774	Remove skin nerve lesion	Y		A2	17.6746	$741.26
64776	Remove digit nerve lesion	Y		A2	17.6746	$741.26
64778	Digit nerve surgery add-on	Y		A2	17.6746	$741.26
64782	Remove limb nerve lesion	Y		A2	17.6746	$741.26
64783	Limb nerve surgery add-on	Y		A2	17.6746	$741.26
64784	Remove nerve lesion	Y		A2	17.6746	$741.26
64786	Remove sciatic nerve lesion	Y		A2	34.4344	$1,444.14
64787	Implant nerve end	Y		A2	17.6746	$741.26

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
64788	Remove skin nerve lesion	Y		A2	17.6746	$741.26
64790	Removal of nerve lesion	Y		A2	17.6746	$741.26
64792	Removal of nerve lesion	Y		A2	34.4344	$1,444.14
64795	Biopsy of nerve	Y		A2	17.6746	$741.26
64802	Remove sympathetic nerves	Y		A2	17.6746	$741.26
64820	Remove sympathetic nerves	Y		G2	17.6746	$741.26
64821	Remove sympathetic nerves	Y		A2	27.5002	$1,153.33
64822	Remove sympathetic nerves	Y		G2	27.5002	$1,153.33
64823	Remove sympathetic nerves	Y		G2	27.5002	$1,153.33
64831	Repair of digit nerve	Y		A2	34.4344	$1,444.14
64832	Repair nerve add-on	Y		A2	34.4344	$1,444.14
64834	Repair of hand or foot nerve	Y		A2	34.4344	$1,444.14
64835	Repair of hand or foot nerve	Y		A2	34.4344	$1,444.14
64836	Repair of hand or foot nerve	Y		A2	34.4344	$1,444.14
64837	Repair nerve add-on	Y		A2	34.4344	$1,444.14
64840	Repair of leg nerve	Y		A2	34.4344	$1,444.14
64856	Repair/transpose nerve	Y		A2	34.4344	$1,444.14
64857	Repair arm/leg nerve	Y		A2	34.4344	$1,444.14
64858	Repair sciatic nerve	Y		A2	34.4344	$1,444.14
64859	Nerve surgery	Y		A2	34.4344	$1,444.14
64861	Repair of arm nerves	Y		A2	34.4344	$1,444.14
64862	Repair of low back nerves	Y		A2	34.4344	$1,444.14
64864	Repair of facial nerve	Y		A2	34.4344	$1,444.14
64865	Repair of facial nerve	Y		A2	34.4344	$1,444.14
64870	Fusion of facial/other nerve	Y		A2	34.4344	$1,444.14
64872	Subsequent repair of nerve	Y		A2	34.4344	$1,444.14
64874	Repair & revise nerve add-on	Y		A2	34.4344	$1,444.14
64876	Repair nerve/shorten bone	Y		A2	34.4344	$1,444.14
64885	Nerve graft head or neck	Y		A2	34.4344	$1,444.14
64886	Nerve graft head or neck	Y		A2	34.4344	$1,444.14
64890	Nerve graft hand or foot	Y		A2	34.4344	$1,444.14
64891	Nerve graft hand or foot	Y		A2	34.4344	$1,444.14
64892	Nerve graft arm or leg	Y		A2	34.4344	$1,444.14
64893	Nerve graft arm or leg	Y		A2	34.4344	$1,444.14
64895	Nerve graft hand or foot	Y		A2	34.4344	$1,444.14
64896	Nerve graft hand or foot	Y		A2	34.4344	$1,444.14

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64897	Nerve graft arm or leg	Y		A2	34.4344	$1,444.14
64898	Nerve graft arm or leg	Y		A2	34.4344	$1,444.14
64901	Nerve graft add-on	Y		A2	34.4344	$1,444.14
64902	Nerve graft add-on	Y		A2	34.4344	$1,444.14
64905	Nerve pedicle transfer	Y		A2	34.4344	$1,444.14
64907	Nerve pedicle transfer	Y		A2	34.4344	$1,444.14
64910	Nerve repair w/allograft	Y		G2	34.4344	$1,444.14
65091	Revise eye	Y		A2	35.8776	$1,504.67
65093	Revise eye with implant	Y		A2	35.8776	$1,504.67
65101	Removal of eye	Y		A2	35.8776	$1,504.67
65103	Remove eye/insert implant	Y		A2	35.8776	$1,504.67
65105	Remove eye/attach implant	Y		A2	35.8776	$1,504.67
65110	Removal of eye	Y		A2	35.8776	$1,504.67
65112	Remove eye/revise socket	Y		A2	35.8776	$1,504.67
65114	Remove eye/revise socket	Y		A2	35.8776	$1,504.67
65125	Revise ocular implant	Y		G2	24.5698	$1,030.43
65130	Insert ocular implant	Y		A2	24.5698	$1,030.43
65135	Insert ocular implant	Y		A2	24.5698	$1,030.43
65140	Attach ocular implant	Y		A2	35.8776	$1,504.67
65150	Revise ocular implant	Y		A2	24.5698	$1,030.43
65155	Reinsert ocular implant	Y		A2	35.8776	$1,504.67
65175	Removal of ocular implant	Y		A2	18.4844	$775.22
65205	Remove foreign body from eye	N		P3		$19.65
65210	Remove foreign body from eye	N		P3		$25.78
65220	Remove foreign body from eye	N		G2	0.8958	$37.57
65222	Remove foreign body from eye	N		P3		$28.07
65235	Remove foreign body from eye	Y		A2	16.538	$693.59
65260	Remove foreign body from eye	Y		A2	5.3998	$226.46
65265	Remove foreign body from eye	Y		A2	21.6452	$907.78
65270	Repair of eye wound	Y		A2	18.4844	$775.22
65272	Repair of eye wound	Y		A2	22.5545	$945.91

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65275	Repair of eye wound	Y		A2	22.5545	$945.91
65280	Repair of eye wound	Y		A2	21.6452	$907.78
65285	Repair of eye wound	Y		A2	37.8357	$1,586.79
65286	Repair of eye wound	Y		P2	6.96	$291.90
65290	Repair of eye socket wound	Y		A2	23.6396	$991.42
65400	Removal of eye lesion	Y		A2	16.538	$693.59
65410	Biopsy of cornea	Y		A2	16.538	$693.59
65420	Removal of eye lesion	Y		A2	16.538	$693.59
65426	Removal of eye lesion	Y		A2	22.5545	$945.91
65430	Corneal smear	N		P2	0.8958	$37.57
65435	Curette/treat cornea	Y		P3		$31.14
65436	Curette/treat cornea	Y		P3		$139.35
65450	Treatment of corneal lesion	N		G2	2.1319	$89.41
65600	Revision of cornea	Y		P3		$160.28
65710	Corneal transplant	Y		A2	35.9619	$1,508.21
65730	Corneal transplant	Y		A2	35.9619	$1,508.21
65750	Corneal transplant	Y		A2	35.9619	$1,508.21
65755	Corneal transplant	Y		A2	35.9619	$1,508.21
65756	Corneal tmspl endothelial	Y		G2	35.9619	$1,508.21
65757	Prep corneal endo allograft	N		N1		
65770	Revise cornea with implant	Y		H8	145.8797	$6,118.05
65772	Correction of astigmatism	Y		A2	16.538	$693.59
65775	Correction of astigmatism	Y		A2	16.538	$693.59
65778	Cover eye w/membrane	Y	NI	G2	7.5037	$314.70
65779	Cover eye w/membrane stent	Y	NI	G2	6.96	$291.90
65780	Ocular reconst transplant	Y		A2	35.9619	$1,508.21
65781	Ocular reconst transplant	Y		A2	35.9619	$1,508.21
65782	Ocular reconst transplant	Y		A2	35.9619	$1,508.21
65800	Drainage of eye	Y		A2	6.96	$291.90
65805	Drainage of eye	Y		A2	16.538	$693.59
65810	Drainage of eye	Y		A2	22.5545	$945.91
65815	Drainage of eye	Y		A2	22.5545	$945.91
65820	Relieve inner eye pressure	Y		A2	22.5545	$945.91
65850	Incision of eye	Y		A2	22.5545	$945.91
65855	Laser surgery of eye	Y		P3		$129.40
65860	Incise inner eye adhesions	Y		P3		$120.21

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65865	Incise inner eye adhesions	Y		A2	16.538	$693.59
65870	Incise inner eye adhesions	Y		A2	22.5545	$945.91
65875	Incise inner eye adhesions	Y		A2	22.5545	$945.91
65880	Incise inner eye adhesions	Y		A2	16.538	$693.59
65900	Remove eye lesion	Y		A2	2.3538	$98.72
65920	Remove implant of eye	Y		A2	22.5545	$945.91
65930	Remove blood clot from eye	Y		A2	22.5545	$945.91
66020	Injection treatment of eye	Y		A2	16.538	$693.59
66030	Injection treatment of eye	Y		A2	16.538	$693.59
66130	Remove eye lesion	Y		A2	22.5545	$945.91
66150	Glaucoma surgery	Y		A2	22.5545	$945.91
66155	Glaucoma surgery	Y		A2	22.5545	$945.91
66160	Glaucoma surgery	Y		A2	22.5545	$945.91
66165	Glaucoma surgery	Y		A2	22.5545	$945.91
66170	Glaucoma surgery	Y		A2	22.5545	$945.91
66172	Incision of eye	Y		A2	22.5545	$945.91
66174	Transluminal eye canal	Y	NI	A2	39.9439	$1,675.21
66175	Trnslum dil eye canal w/stnt	Y	NI	A2	39.9439	$1,675.21
66180	Implant eye shunt	Y		A2	39.9439	$1,675.21
66185	Revise eye shunt	Y		A2	22.5545	$945.91
66220	Repair eye lesion	Y		A2	37.8357	$1,586.79
66225	Repair/graft eye lesion	Y		A2	39.9439	$1,675.21
66250	Follow-up surgery of eye	Y		A2	16.538	$693.59
66500	Incision of iris	Y		A2	2.3538	$98.72
66505	Incision of iris	Y		A2	6.96	$291.90
66600	Remove iris and lesion	Y		A2	22.5545	$945.91
66605	Removal of iris	Y		A2	22.5545	$945.91
66625	Removal of iris	Y		A2	6.96	$291.90
66630	Removal of iris	Y		A2	22.5545	$945.91
66635	Removal of iris	Y		A2	22.5545	$945.91
66680	Repair iris & ciliary body	Y		A2	22.5545	$945.91
66682	Repair iris & ciliary body	Y		A2	22.5545	$945.91
66700	Destruction ciliary body	Y		A2	16.538	$693.59
66710	Ciliary transscleral therapy	Y		A2	16.538	$693.59
66711	Ciliary endoscopic ablation	Y		A2	16.538	$693.59
66720	Destruction ciliary body	Y		A2	16.538	$693.59

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66740	Destruction ciliary body	Y		A2	22.5545	$945.91
66761	Revision of iris	Y		P3		$149.30
66762	Revision of iris	Y		P3		$185.29
66770	Removal of inner eye lesion	Y		P3		$201.37
66820	Incision secondary cataract	Y		G2	6.96	$291.90
66821	After cataract laser surgery	Y		A2	5.1831	$217.37
66825	Reposition intraocular lens	Y		A2	22.5545	$945.91
66830	Removal of lens lesion	Y		A2	6.96	$291.90
66840	Removal of lens material	Y		A2	13.643	$572.17
66850	Removal of lens material	Y		A2	28.4753	$1,194.23
66852	Removal of lens material	Y		A2	28.4753	$1,194.23
66920	Extraction of lens	Y		A2	28.4753	$1,194.23
66930	Extraction of lens	Y		A2	28.4753	$1,194.23
66940	Extraction of lens	Y		A2	13.643	$572.17
66982	Cataract surgery complex	Y		A2	22.6822	$951.27
66983	Cataract surg w/iol 1 stage	Y		A2	22.6822	$951.27
66984	Cataract surg w/iol 1 stage	Y		A2	22.6822	$951.27
66985	Insert lens prosthesis	Y		A2	22.6822	$951.27
66986	Exchange lens prosthesis	Y		A2	22.6822	$951.27
66990	Ophthalmic endoscope add-on	N		N1		
67005	Partial removal of eye fluid	Y		A2	21.6452	$907.78
67010	Partial removal of eye fluid	Y		A2	37.8357	$1,586.79
67015	Release of eye fluid	Y		A2	37.8357	$1,586.79
67025	Replace eye fluid	Y		A2	37.8357	$1,586.79
67027	Implant eye drug system	Y		A2	37.8357	$1,586.79
67028	Injection eye drug	Y		P3		$54.62
67030	Incise inner eye strands	Y		A2	21.6452	$907.78
67031	Laser surgery eye strands	Y		A2	5.1831	$217.37
67036	Removal of inner eye fluid	Y		A2	37.8357	$1,586.79
67039	Laser treatment of retina	Y		A2	37.8357	$1,586.79
67040	Laser treatment of retina	Y		A2	37.8357	$1,586.79
67041	Vit for macular pucker	Y		G2	37.8357	$1,586.79
67042	Vit for macular hole	Y		G2	37.8357	$1,586.79
67043	Vit for membrane dissect	Y		G2	37.8357	$1,586.79
67101	Repair detached retina	Y		P3		$306.52
67105	Repair detached retina	Y		P2	5.1831	$217.37

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67107	Repair detached retina	Y		A2	37.8357	$1,586.79
67108	Repair detached retina	Y		A2	37.8357	$1,586.79
67110	Repair detached retina	Y		P3		$328.72
67112	Rerepair detached retina	Y		A2	37.8357	$1,586.79
67113	Repair retinal detach cplx	Y		G2	37.8357	$1,586.79
67115	Release encircling material	Y		A2	21.6452	$907.78
67120	Remove eye implant material	Y		A2	21.6452	$907.78
67121	Remove eye implant material	Y		A2	37.8357	$1,586.79
67141	Treatment of retina	Y		A2	5.3998	$226.46
67145	Treatment of retina	Y		P3		$195.75
67208	Treatment of retinal lesion	Y		P3		$210.81
67210	Treatment of retinal lesion	Y		P2	5.1831	$217.37
67218	Treatment of retinal lesion	Y		A2	21.6452	$907.78
67220	Treatment of choroid lesion	Y		P2	5.3998	$226.46
67221	Ocular photodynamic ther	Y		P3		$111.27
67225	Eye photodynamic ther add-on	Y		P3		$8.42
67227	Treatment of retinal lesion	Y		A2	21.6452	$907.78
67228	Treatment of retinal lesion	Y		P2	5.1831	$217.37
67229*	Tr retinal les preterm inf	Y		R2	5.1831	$217.37
67250	Reinforce eye wall	Y		A2	18.4844	$775.22
67255	Reinforce/graft eye wall	Y		A2	21.6452	$907.78
67311	Revise eye muscle	Y		A2	23.6396	$991.42
67312	Revise two eye muscles	Y		A2	23.6396	$991.42
67314	Revise eye muscle	Y		A2	23.6396	$991.42
67316	Revise two eye muscles	Y		A2	23.6396	$991.42
67318	Revise eye muscle(s)	Y		A2	23.6396	$991.42
67320	Revise eye muscle(s) add-on	Y		A2	23.6396	$991.42
67331	Eye surgery follow-up add-on	Y		A2	23.6396	$991.42
67332	Rerevise eye muscles add-on	Y		A2	23.6396	$991.42
67334	Revise eye muscle w/suture	Y		A2	23.6396	$991.42
67335	Eye suture during surgery	Y		A2	23.6396	$991.42
67340	Revise eye muscle add-on	Y		A2	23.6396	$991.42
67343	Release eye tissue	Y		A2	23.6396	$991.42
67345	Destroy nerve of eye muscle	Y		P3		$82.18
67346	Biopsy eye muscle	Y		A2	15.5071	$650.35
67400	Explore/biopsy eye socket	Y		A2	18.4844	$775.22

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67405	Explore/drain eye socket	Y		A2	24.5698	$1,030.43
67412	Explore/treat eye socket	Y		A2	18.4844	$775.22
67413	Explore/treat eye socket	Y		A2	24.5698	$1,030.43
67414	Explr/decompress eye socket	Y		G2	35.8776	$1,504.67
67415	Aspiration orbital contents	Y		A2	18.4844	$775.22
67420	Explore/treat eye socket	Y		A2	35.8776	$1,504.67
67430	Explore/treat eye socket	Y		A2	35.8776	$1,504.67
67440	Explore/drain eye socket	Y		A2	35.8776	$1,504.67
67445	Explr/decompress eye socket	Y		A2	35.8776	$1,504.67
67450	Explore/biopsy eye socket	Y		A2	35.8776	$1,504.67
67500	Inject/treat eye socket	N		G2	2.1319	$89.41
67505	Inject/treat eye socket	Y		P3		$27.82
67515	Inject/treat eye socket	Y		P3		$29.09
67550	Insert eye socket implant	Y		A2	35.8776	$1,504.67
67560	Revise eye socket implant	Y		A2	24.5698	$1,030.43
67570	Decompress optic nerve	Y		A2	35.8776	$1,504.67
67700	Drainage of eyelid abscess	Y		P2	3.0042	$125.99
67710	Incision of eyelid	Y		P3		$128.63
67715	Incision of eyelid fold	Y		A2	18.4844	$775.22
67800	Remove eyelid lesion	Y		P3		$50.53
67801	Remove eyelid lesions	Y		P3		$61.51
67805	Remove eyelid lesions	Y		P3		$79.37
67808	Remove eyelid lesion(s)	Y		A2	18.4844	$775.22
67810	Biopsy of eyelid	Y		P3		$116.89
67820	Revise eyelashes	N		P3		$16.59
67825	Revise eyelashes	Y		P3		$51.30
67830	Revise eyelashes	Y		A2	7.5037	$314.70
67835	Revise eyelashes	Y		A2	18.4844	$775.22
67840	Remove eyelid lesion	Y		P3		$137.62
67850	Treat eyelid lesion	Y		P3		$108.21
67875	Closure of eyelid by suture	Y		G2	7.5037	$314.70
67880	Revision of eyelid	Y		A2	16.538	$693.59
67882	Revision of eyelid	Y		A2	18.4844	$775.22
67900	Repair brow defect	Y		A2	24.5698	$1,030.43
67901	Repair eyelid defect	Y		A2	18.4844	$775.22
67902	Repair eyelid defect	Y		A2	24.5698	$1,030.43

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
67903	Repair eyelid defect	Y		A2	18.4844	$775.22
67904	Repair eyelid defect	Y		A2	18.4844	$775.22
67906	Repair eyelid defect	Y		A2	18.4844	$775.22
67908	Repair eyelid defect	Y		A2	18.4844	$775.22
67909	Revise eyelid defect	Y		A2	18.4844	$775.22
67911	Revise eyelid defect	Y		A2	18.4844	$775.22
67912	Correction eyelid w/implant	Y		A2	18.4844	$775.22
67914	Repair eyelid defect	Y		A2	18.4844	$775.22
67915	Repair eyelid defect	Y		P3		$155.43
67916	Repair eyelid defect	Y		A2	18.4844	$775.22
67917	Repair eyelid defect	Y		A2	18.4844	$775.22
67921	Repair eyelid defect	Y		A2	18.4844	$775.22
67922	Repair eyelid defect	Y		P3		$150.83
67923	Repair eyelid defect	Y		A2	18.4844	$775.22
67924	Repair eyelid defect	Y		A2	18.4844	$775.22
67930	Repair eyelid wound	Y		P3		$157.72
67935	Repair eyelid wound	Y		A2	18.4844	$775.22
67938	Remove eyelid foreign body	N		P2	2.1319	$89.41
67950	Revision of eyelid	Y		A2	18.4844	$775.22
67961	Revision of eyelid	Y		A2	18.4844	$775.22
67966	Revision of eyelid	Y		A2	18.4844	$775.22
67971	Reconstruction of eyelid	Y		A2	18.4844	$775.22
67973	Reconstruction of eyelid	Y		A2	24.5698	$1,030.43
67974	Reconstruction of eyelid	Y		A2	18.4844	$775.22
67975	Reconstruction of eyelid	Y		A2	18.4844	$775.22
68020	Incise/drain eyelid lining	Y		P3		$45.17
68040	Treatment of eyelid lesions	N		P3		$22.71
68100	Biopsy of eyelid lining	Y		P3		$82.95
68110	Remove eyelid lining lesion	Y		P3		$108.47
68115	Remove eyelid lining lesion	Y		A2	18.4844	$775.22
68130	Remove eyelid lining lesion	Y		A2	16.538	$693.59
68135	Remove eyelid lining lesion	Y		P3		$58.19
68200	Treat eyelid by injection	N		P3		$16.33
68320	Revise/graft eyelid lining	Y		A2	24.5698	$1,030.43
68325	Revise/graft eyelid lining	Y		A2	24.5698	$1,030.43
68326	Revise/graft eyelid lining	Y		A2	18.4844	$775.22

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
68328	Revise/graft eyelid lining	Y		A2	24.5698	$1,030.43
68330	Revise eyelid lining	Y		A2	22.5545	$945.91
68335	Revise/graft eyelid lining	Y		A2	24.5698	$1,030.43
68340	Separate eyelid adhesions	Y		A2	18.4844	$775.22
68360	Revise eyelid lining	Y		A2	22.5545	$945.91
68362	Revise eyelid lining	Y		A2	22.5545	$945.91
68371	Harvest eye tissue alograft	Y		A2	16.538	$693.59
68400	Incise/drain tear gland	Y		P2	3.0042	$125.99
68420	Incise/drain tear sac	Y		P3		$161.04
68440	Incise tear duct opening	Y		P3		$46.70
68500	Removal of tear gland	Y		A2	24.5698	$1,030.43
68505	Partial removal tear gland	Y		A2	24.5698	$1,030.43
68510	Biopsy of tear gland	Y		A2	18.4844	$775.22
68520	Removal of tear sac	Y		A2	24.5698	$1,030.43
68525	Biopsy of tear sac	Y		A2	18.4844	$775.22
68530	Clearance of tear duct	Y		P2	3.0042	$125.99
68540	Remove tear gland lesion	Y		A2	18.4844	$775.22
68550	Remove tear gland lesion	Y		A2	24.5698	$1,030.43
68700	Repair tear ducts	Y		A2	18.4844	$775.22
68705	Revise tear duct opening	Y		P3		$108.98
68720	Create tear sac drain	Y		A2	24.5698	$1,030.43
68745	Create tear duct drain	Y		A2	24.5698	$1,030.43
68750	Create tear duct drain	Y		A2	24.5698	$1,030.43
68760	Close tear duct opening	Y		P3		$92.64
68761	Close tear duct opening	Y		P3		$65.08
68770	Close tear system fistula	Y		A2	24.5698	$1,030.43
68801	Dilate tear duct opening	N		P2	0.8958	$37.57
68810	Probe nasolacrimal duct	Y		A2	3.0042	$125.99
68811	Probe nasolacrimal duct	Y		A2	18.4844	$775.22
68815	Probe nasolacrimal duct	Y		A2	18.4844	$775.22
68816	Probe nl duct w/balloon	Y		G2	18.4844	$775.22
68840	Explore/irrigate tear ducts	N		P3		$53.34
68850	Injection for tear sac x-ray	N		N1		
69000	Drain external ear lesion	Y		P2	1.377	$57.75
69005	Drain external ear lesion	Y		P3		$98.26
69020	Drain outer ear canal lesion	Y		P2	1.377	$57.75

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
69100	Biopsy of external ear	Y		P3		$54.11
69105	Biopsy of external ear canal	Y		P3		$81.67
69110	Remove external ear partial	Y		A2	16.7008	$700.41
69120	Removal of external ear	Y		A2	23.6929	$993.66
69140	Remove ear canal lesion(s)	Y		A2	23.6929	$993.66
69145	Remove ear canal lesion(s)	Y		A2	16.7008	$700.41
69150	Extensive ear canal surgery	Y		A2	7.3159	$306.82
69200	Clear outer ear canal	N		P2	0.6201	$26.01
69205	Clear outer ear canal	Y		A2	22.0775	$925.91
69210	Remove impacted ear wax	N		P3		$20.16
69220	Clean out mastoid cavity	Y		P2	0.8409	$35.27
69222	Clean out mastoid cavity	Y		P3		$125.06
69300	Revise external ear	Y		A2	23.6929	$993.66
69310	Rebuild outer ear canal	Y		A2	41.2845	$1,731.43
69320	Rebuild outer ear canal	Y		A2	41.2845	$1,731.43
69400	Inflate middle ear canal	Y		P3		$86.01
69401	Inflate middle ear canal	Y		P3		$45.94
69405	Catheterize middle ear canal	Y		P3		$119.95
69420	Incision of eardrum	Y		P3		$104.89
69421	Incision of eardrum	Y		A2	16.0176	$671.76
69424	Remove ventilating tube	Y		P3		$72.99
69433	Create eardrum opening	Y		P3		$105.40
69436	Create eardrum opening	Y		A2	16.0176	$671.76
69440	Exploration of middle ear	Y		A2	23.6929	$993.66
69450	Eardrum revision	Y		A2	41.2845	$1,731.43
69501	Mastoidectomy	Y		A2	41.2845	$1,731.43
69502	Mastoidectomy	Y		A2	23.6929	$993.66
69505	Remove mastoid structures	Y		A2	41.2845	$1,731.43
69511	Extensive mastoid surgery	Y		A2	41.2845	$1,731.43
69530	Extensive mastoid surgery	Y		A2	41.2845	$1,731.43
69540	Remove ear lesion	Y		P3		$122.25
69550	Remove ear lesion	Y		A2	41.2845	$1,731.43
69552	Remove ear lesion	Y		A2	41.2845	$1,731.43
69601	Mastoid surgery revision	Y		A2	41.2845	$1,731.43
69602	Mastoid surgery revision	Y		A2	41.2845	$1,731.43
69603	Mastoid surgery revision	Y		A2	41.2845	$1,731.43

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011
(INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
69604	Mastoid surgery revision	Y		A2	41.2845	$1,731.43
69605	Mastoid surgery revision	Y		A2	41.2845	$1,731.43
69610	Repair of eardrum	Y		P3		$165.89
69620	Repair of eardrum	Y		A2	23.6929	$993.66
69631	Repair eardrum structures	Y		A2	41.2845	$1,731.43
69632	Rebuild eardrum structures	Y		A2	41.2845	$1,731.43
69633	Rebuild eardrum structures	Y		A2	41.2845	$1,731.43
69635	Repair eardrum structures	Y		A2	41.2845	$1,731.43
69636	Rebuild eardrum structures	Y		A2	41.2845	$1,731.43
69637	Rebuild eardrum structures	Y		A2	41.2845	$1,731.43
69641	Revise middle ear & mastoid	Y		A2	41.2845	$1,731.43
69642	Revise middle ear & mastoid	Y		A2	41.2845	$1,731.43
69643	Revise middle ear & mastoid	Y		A2	41.2845	$1,731.43
69644	Revise middle ear & mastoid	Y		A2	41.2845	$1,731.43
69645	Revise middle ear & mastoid	Y		A2	41.2845	$1,731.43
69646	Revise middle ear & mastoid	Y		A2	41.2845	$1,731.43
69650	Release middle ear bone	Y		A2	23.6929	$993.66
69660	Revise middle ear bone	Y		A2	41.2845	$1,731.43
69661	Revise middle ear bone	Y		A2	41.2845	$1,731.43
69662	Revise middle ear bone	Y		A2	41.2845	$1,731.43
69666	Repair middle ear structures	Y		A2	41.2845	$1,731.43
69667	Repair middle ear structures	Y		A2	41.2845	$1,731.43
69670	Remove mastoid air cells	Y		A2	41.2845	$1,731.43
69676	Remove middle ear nerve	Y		A2	41.2845	$1,731.43
69700	Close mastoid fistula	Y		A2	41.2845	$1,731.43
69711	Remove/repair hearing aid	Y		A2	41.2845	$1,731.43
69714	Implant temple bone w/stimul	Y		H8	168.536	$7,068.23
69715	Temple bne implnt w/stimulat	Y		H8	168.536	$7,068.23
69717	Temple bone implant revision	Y		H8	168.536	$7,068.23
69718	Revise temple bone implant	Y		H8	168.536	$7,068.23
69720	Release facial nerve	Y		A2	41.2845	$1,731.43
69740	Repair facial nerve	Y		A2	41.2845	$1,731.43
69745	Repair facial nerve	Y		A2	41.2845	$1,731.43
69801	Incise inner ear	Y	NI	A2	16.0176	$671.76
69802	Incise inner ear	Y	NI	G2	23.6929	$993.66
69805	Explore inner ear	Y		A2	41.2845	$1,731.43

ADDENDUM AA.—FINAL ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
69806	Explore inner ear	Y		A2	41.2845	$1,731.43
69820	Establish inner ear window	Y		A2	41.2845	$1,731.43
69840	Revise inner ear window	Y		A2	41.2845	$1,731.43
69905	Remove inner ear	Y		A2	41.2845	$1,731.43
69910	Remove inner ear & mastoid	Y		A2	41.2845	$1,731.43
69915	Incise inner ear nerve	Y		A2	41.2845	$1,731.43
69930	Implant cochlear device	Y		H8	692.8193	$29,056.15
69990	Microsurgery add-on	N		N1		
C9716	Radiofrequency energy to anu	Y		G2	30.1708	$1,265.33
C9724	EPS gast cardia plic	Y		G2	15.4076	$646.18
C9725	Place endorectal app	Y		G2	5.5574	$233.07
C9726	Rxt breast appl place/remov	Y		G2	23.641	$991.48
C9727	Insert palate implants	Y		G2	7.3159	$306.82
C9728	Place device/marker, non pro	N		R2	12.4299	$521.30
C9800*	Dermal filler inj px/suppl	Y		R2	4.2885	$179.86
G0104**	CA screen;flexi sigmoidscope	N		P3		$75.54
G0105**	Colorectal scrn; hi risk ind	Y		A2	7.6437	$320.57
G0121**	Colon ca scrn not hi rsk ind	Y		A2	7.6437	$320.57
G0127	Trim nail(s)	Y		P3		$11.48
G0186	Dstry eye lesn,fdr vssl tech	Y		R2	5.3998	$226.46
G0247	Routine footcare pt w lops	Y		P3		$29.86
G0259	Inject for sacroiliac joint	N		N1		
G0260	Inj for sacroiliac jt anesth	Y		A2	7.0103	$294.00
G0268	Removal of impacted wax md	N		N1		
G0269	Occlusive device in vein art	N		N1		
G0289	Arthro, loose body + chondro	N		N1		
G0364	Bone marrow aspirate &biopsy	N		P3		$4.85

Note: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount. Section 4104 of the Affordable Care Act (ACA) waives coinsurance for most preventive services, identified with a double asterisk (**).

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00100	Anesth salivary gland		N					
00102	Anesth repair of cleft lip		N					
00103	Anesth blepharoplasty		N					
00104	Anesth electroshock		N					
00120	Anesth ear surgery		N					
00124	Anesth ear exam		N					
00126	Anesth tympanotomy		N					
00140	Anesth procedures on eye		N					
00142	Anesth lens surgery		N					
00144	Anesth corneal transplant		N					
00145	Anesth vitreoretinal surg		N					
00147	Anesth iridectomy		N					
00148	Anesth eye exam		N					
00160	Anesth nose/sinus surgery		N					
00162	Anesth nose/sinus surgery		N					
00164	Anesth biopsy of nose		N					
00170	Anesth procedure on mouth		N					
00172	Anesth cleft palate repair		N					
00174	Anesth pharyngeal surgery		N					
00176	Anesth pharyngeal surgery		C					
00190	Anesth face/skull bone surg		N					
00192	Anesth facial bone surgery		C					
00210	Anesth cranial surg nos		N					
00211	Anesth cran surg hemotoma		C					
00212	Anesth skull drainage		N					
00214	Anesth skull drainage		C					
00215	Anesth skull repair/fract		C					
00216	Anesth head vessel surgery		N					
00218	Anesth special head surgery		N					
00220	Anesth intrcrn nerve		N					
00222	Anesth head nerve surgery		N					
00300	Anesth head/neck/ptrunk		N					
00320	Anesth neck organ 1 & over		N					
00322	Anesth biopsy of thyroid		N					
00326	Anesth larynx/trach < 1 yr		N					
00350	Anesth neck vessel surgery		N					
00352	Anesth neck vessel surgery		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00400	Anesth skin ext/per/atrunk		N					
00402	Anesth surgery of breast		N					
00404	Anesth surgery of breast		N					
00406	Anesth surgery of breast		N					
00410	Anesth correct heart rhythm		N					
00450	Anesth surgery of shoulder		N					
00452	Anesth surgery of shoulder		C					
00454	Anesth collar bone biopsy		N					
00470	Anesth removal of rib		N					
00472	Anesth chest wall repair		N					
00474	Anesth surgery of rib(s)		C					
00500	Anesth esophageal surgery		N					
00520	Anesth chest procedure		N					
00522	Anesth chest lining biopsy		N					
00524	Anesth chest drainage		C					
00528	Anesth chest partition view		N					
00529	Anesth chest partition view		N					
00530	Anesth pacemaker insertion		N					
00532	Anesth vascular access		N					
00534	Anesth cardioverter/defib		N					
00537	Anesth cardiac electrophys		N					
00539	Anesth trach-bronch reconst		N					
00540	Anesth chest surgery		C					
00541	Anesth one lung ventilation		N					
00542	Anesth release of lung		C					
00546	Anesth lung chest wall surg		C					
00548	Anesth trachea bronchi surg		N					
00550	Anesth sternal debridement		N					
00560	Anesth heart surg w/o pump		C					
00561	Anesth heart surg < 1 yr		C					
00562	Anesth hrt surg w/pmp age 1+		C					
00563	Anesth heart surg w/arrest		N					
00566	Anesth cabg w/o pump		N					
00567	Anesth cabg w/pump		C					
00580	Anesth heart/lung transplnt		C					
00600	Anesth spine cord surgery		N					
00604	Anesth sitting procedure		C					
00620	Anesth spine cord surgery		N					
00622	Anesth removal of nerves		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00625	Anes spine tranthor w/o vent		N					
00626	Anes spine transthor w/vent		N					
00630	Anesth spine cord surgery		N					
00632	Anesth removal of nerves		C					
00634	Anesth for chemonucleolysis		N					
00635	Anesth lumbar puncture		N					
00640	Anesth spine manipulation		N					
00670	Anesth spine cord surgery		C					
00700	Anesth abdominal wall surg		N					
00702	Anesth for liver biopsy		N					
00730	Anesth abdominal wall surg		N					
00740	Anesth upper gi visualize		N					
00750	Anesth repair of hernia		N					
00752	Anesth repair of hernia		N					
00754	Anesth repair of hernia		N					
00756	Anesth repair of hernia		N					
00770	Anesth blood vessel repair		N					
00790	Anesth surg upper abdomen		N					
00792	Anesth hemorr/excise liver		C					
00794	Anesth pancreas removal		C					
00796	Anesth for liver transplant		C					
00797	Anesth surgery for obesity		N					
00800	Anesth abdominal wall surg		N					
00802	Anesth fat layer removal		C					
00810	Anesth low intestine scope		N					
00820	Anesth abdominal wall surg		N					
00830	Anesth repair of hernia		N					
00832	Anesth repair of hernia		N					
00834	Anesth hernia repair < 1 yr		N					
00836	Anesth hernia repair preemie		N					
00840	Anesth surg lower abdomen		N					
00842	Anesth amniocentesis		N					
00844	Anesth pelvis surgery		C					
00846	Anesth hysterectomy		C					
00848	Anesth pelvic organ surg		C					
00851	Anesth tubal ligation		N					
00860	Anesth surgery of abdomen		N					
00862	Anesth kidney/ureter surg		N					
00864	Anesth removal of bladder		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00865	Anesth removal of prostate		C					
00866	Anesth removal of adrenal		C					
00868	Anesth kidney transplant		C					
00870	Anesth bladder stone surg		N					
00872	Anesth kidney stone destruct		N					
00873	Anesth kidney stone destruct		N					
00880	Anesth abdomen vessel surg		N					
00882	Anesth major vein ligation		C					
00902	Anesth anorectal surgery		N					
00904	Anesth perineal surgery		C					
00906	Anesth removal of vulva		N					
00908	Anesth removal of prostate		C					
00910	Anesth bladder surgery		N					
00912	Anesth bladder tumor surg		N					
00914	Anesth removal of prostate		N					
00916	Anesth bleeding control		N					
00918	Anesth stone removal		N					
00920	Anesth genitalia surgery		N					
00921	Anesth vasectomy		N					
00922	Anesth sperm duct surgery		N					
00924	Anesth testis exploration		N					
00926	Anesth removal of testis		N					
00928	Anesth removal of testis		N					
00930	Anesth testis suspension		N					
00932	Anesth amputation of penis		C					
00934	Anesth penis nodes removal		C					
00936	Anesth penis nodes removal		C					
00938	Anesth insert penis device		N					
00940	Anesth vaginal procedures		N					
00942	Anesth surg on vag/urethral		N					
00944	Anesth vaginal hysterectomy		C					
00948	Anesth repair of cervix		N					
00950	Anesth vaginal endoscopy		N					
00952	Anesth hysteroscope/graph		N					
01112	Anesth bone aspirate/bx		N					
01120	Anesth pelvis surgery		N					
01130	Anesth body cast procedure		N					
01140	Anesth amputation at pelvis		C					
01150	Anesth pelvic tumor surgery		C					

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01160	Anesth pelvis procedure		N					
01170	Anesth pelvis surgery		N					
01173	Anesth fx repair pelvis		N					
01180	Anesth pelvis nerve removal		N					
01190	Anesth pelvis nerve removal		N					
01200	Anesth hip joint procedure		N					
01202	Anesth arthroscopy of hip		N					
01210	Anesth hip joint surgery		N					
01212	Anesth hip disarticulation		C					
01214	Anesth hip arthroplasty		C					
01215	Anesth revise hip repair		N					
01220	Anesth procedure on femur		N					
01230	Anesth surgery of femur		N					
01232	Anesth amputation of femur		C					
01234	Anesth radical femur surg		C					
01250	Anesth upper leg surgery		N					
01260	Anesth upper leg veins surg		N					
01270	Anesth thigh arteries surg		N					
01272	Anesth femoral artery surg		C					
01274	Anesth femoral embolectomy		C					
01320	Anesth knee area surgery		N					
01340	Anesth knee area procedure		N					
01360	Anesth knee area surgery		N					
01380	Anesth knee joint procedure		N					
01382	Anesth dx knee arthroscopy		N					
01390	Anesth knee area procedure		N					
01392	Anesth knee area surgery		N					
01400	Anesth knee joint surgery		N					
01402	Anesth knee arthroplasty		C					
01404	Anesth amputation at knee		C					
01420	Anesth knee joint casting		N					
01430	Anesth knee veins surgery		N					
01432	Anesth knee vessel surg		N					
01440	Anesth knee arteries surg		N					
01442	Anesth knee artery surg		C					
01444	Anesth knee artery repair		C					
01462	Anesth lower leg procedure		N					
01464	Anesth ankle/ft arthroscopy		N					
01470	Anesth lower leg surgery		N					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01472	Anesth achilles tendon surg		N					
01474	Anesth lower leg surgery		N					
01480	Anesth lower leg bone surg		N					
01482	Anesth radical leg surgery		N					
01484	Anesth lower leg revision		N					
01486	Anesth ankle replacement		C					
01490	Anesth lower leg casting		N					
01500	Anesth leg arteries surg		N					
01502	Anesth lwr leg embolectomy		C					
01520	Anesth lower leg vein surg		N					
01522	Anesth lower leg vein surg		N					
01610	Anesth surgery of shoulder		N					
01620	Anesth shoulder procedure		N					
01622	Anes dx shoulder arthroscopy		N					
01630	Anesth surgery of shoulder		N					
01634	Anesth shoulder joint amput		C					
01636	Anesth forequarter amput		C					
01638	Anesth shoulder replacement		C					
01650	Anesth shoulder artery surg		N					
01652	Anesth shoulder vessel surg		C					
01654	Anesth shoulder vessel surg		C					
01656	Anesth arm-leg vessel surg		C					
01670	Anesth shoulder vein surg		N					
01680	Anesth shoulder casting		N					
01682	Anesth airplane cast		N					
01710	Anesth elbow area surgery		N					
01712	Anesth uppr arm tendon surg		N					
01714	Anesth uppr arm tendon surg		N					
01716	Anesth biceps tendon repair		N					
01730	Anesth uppr arm procedure		N					
01732	Anesth dx elbow arthroscopy		N					
01740	Anesth upper arm surgery		N					
01742	Anesth humerus surgery		N					
01744	Anesth humerus repair		N					
01756	Anesth radical humerus surg		C					
01758	Anesth humeral lesion surg		N					
01760	Anesth elbow replacement		N					
01770	Anesth uppr arm artery surg		N					
01772	Anesth uppr arm embolectomy		N					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01780	Anesth upper arm vein surg		N					
01782	Anesth uppr arm vein repair		N					
01810	Anesth lower arm surgery		N					
01820	Anesth lower arm procedure		N					
01829	Anesth dx wrist arthroscopy		N					
01830	Anesth lower arm surgery		N					
01832	Anesth wrist replacement		N					
01840	Anesth lwr arm artery surg		N					
01842	Anesth lwr arm embolectomy		N					
01844	Anesth vascular shunt surg		N					
01850	Anesth lower arm vein surg		N					
01852	Anesth lwr arm vein repair		N					
01860	Anesth lower arm casting		N					
01916	Anesth dx arteriography		N					
01920	Anesth catheterize heart		N					
01922	Anesth cat or mri scan		N					
01924	Anes ther interven rad art		N					
01925	Anes ther interven rad car		N					
01926	Anes tx interv rad hrt/cran		N					
01930	Anes ther interven rad vei		N					
01931	Anes ther interven rad tip		N					
01932	Anes tx interv rad th vein		N					
01933	Anes tx interv rad cran v		N					
01935	Anesth perc img dx sp proc		N					
01936	Anesth perc img tx sp proc		N					
01951	Anesth burn less 4 percent		N					
01952	Anesth burn 4-9 percent		N					
01953	Anesth burn each 9 percent		N					
01958	Anesth antepartum manipul		N					
01960	Anesth vaginal delivery		N					
01961	Anesth cs delivery		N					
01962	Anesth emer hysterectomy		N					
01963	Anesth cs hysterectomy		N					
01965	Anesth inc/missed ab proc		N					
01966	Anesth induced ab procedure		N					
01967	Anesth/analg vag delivery		N					
01968	Anes/analg cs deliver add-on		N					
01969	Anesth/analg cs hyst add-on		N					
01990	Support for organ donor		C					

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01991	Anesth nerve block/inj		N					
01992	Anesth n block/inj prone		N					
01996	Hosp manage cont drug admin		N					
01999	Unlisted anesth procedure		N					
10021	Fna w/o image		T	0002	1.5703	$108.16	.	$21.64
10022	Fna w/image		T	0004	4.5843	$315.75	.	$63.15
10040	Acne surgery		T	0013	0.9103	$62.70	.	$12.54
10060	Drainage of skin abscess		T	0006	1.4906	$102.67	.	$20.54
10061	Drainage of skin abscess		T	0006	1.4906	$102.67	.	$20.54
10080	Drainage of pilonidal cyst		T	0006	1.4906	$102.67	.	$20.54
10081	Drainage of pilonidal cyst		T	0007	13.0129	$896.28	.	$179.26
10120	Remove foreign body		T	0016	2.7318	$188.16	.	$37.64
10121	Remove foreign body		T	0021	18.0784	$1,245.17	.	$249.04
10140	Drainage of hematoma/fluid		T	0007	13.0129	$896.28	.	$179.26
10160	Puncture drainage of lesion		T	0006	1.4906	$102.67	.	$20.54
10180	Complex drainage wound		T	0008	20.1996	$1,391.27	.	$278.26
11000	Debride infected skin	CH	T	0016	2.7318	$188.16	.	$37.64
11001	Debride infected skin add-on		T	0013	0.9103	$62.70	.	$12.54
11004	Debride genitalia & perineum		C					
11005	Debride abdom wall		C					
11006	Debride genit/per/abdom wall		C					
11008	Remove mesh from abd wall		C					
11010	Debride skin at fx site		T	0019	5.0887	$350.49	.	$70.10
11011	Debride skin musc at fx site		T	0019	5.0887	$350.49	.	$70.10
11012	Deb skin bone at fx site		T	0019	5.0887	$350.49	.	$70.10
11040	Debride skin, partial	CH	D					
11041	Debride skin, full	CH	D					
11042	Deb subq tissue 20 sq cm/<		T	0016	2.7318	$188.16	.	$37.64
11043	Deb musc/fascia 20 sq cm/<		T	0016	2.7318	$188.16	.	$37.64
11044	Deb bone 20 sq cm/<		T	0020	8.4929	$584.96	.	$117.00
11045	Deb subq tissue add-on	NI	T	0016	2.7318	$188.16	.	$37.64
11046	Deb musc/fascia add-on	NI	T	0016	2.7318	$188.16	.	$37.64
11047	Deb bone add-on	NI	T	0020	8.4929	$584.96	.	$117.00
11055	Trim skin lesion		T	0013	0.9103	$62.70	.	$12.54
11056	Trim skin lesions 2 to 4		T	0013	0.9103	$62.70	.	$12.54
11057	Trim skin lesions over 4		T	0013	0.9103	$62.70	.	$12.54
11100	Biopsy skin lesion		T	0015	1.4975	$103.14	.	$20.63
11101	Biopsy skin add-on		T	0013	0.9103	$62.70	.	$12.54
11200	Removal of skin tags		T	0013	0.9103	$62.70	.	$12.54

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11201	Remove skin tags add-on		T	0013	0.9103	$62.70	.	$12.54
11300	Shave skin lesion		T	0013	0.9103	$62.70	.	$12.54
11301	Shave skin lesion		T	0013	0.9103	$62.70	.	$12.54
11302	Shave skin lesion		T	0013	0.9103	$62.70	.	$12.54
11303	Shave skin lesion		T	0015	1.4975	$103.14	.	$20.63
11305	Shave skin lesion		T	0013	0.9103	$62.70	.	$12.54
11306	Shave skin lesion		T	0013	0.9103	$62.70	.	$12.54
11307	Shave skin lesion		T	0013	0.9103	$62.70	.	$12.54
11308	Shave skin lesion		T	0013	0.9103	$62.70	.	$12.54
11310	Shave skin lesion		T	0013	0.9103	$62.70	.	$12.54
11311	Shave skin lesion		T	0013	0.9103	$62.70	.	$12.54
11312	Shave skin lesion		T	0013	0.9103	$62.70	.	$12.54
11313	Shave skin lesion		T	0013	0.9103	$62.70	.	$12.54
11400	Exc tr-ext b9+marg 0.5 < cm		T	0019	5.0887	$350.49	.	$70.10
11401	Exc tr-ext b9+marg 0.6-1 cm		T	0019	5.0887	$350.49	.	$70.10
11402	Exc tr-ext b9+marg 1.1-2 cm		T	0019	5.0887	$350.49	.	$70.10
11403	Exc tr-ext b9+marg 2.1-3 cm		T	0020	8.4929	$584.96	.	$117.00
11404	Exc tr-ext b9+marg 3.1-4 cm		T	0021	18.0784	$1,245.17	.	$249.04
11406	Exc tr-ext b9+marg > 4.0 cm		T	0021	18.0784	$1,245.17	.	$249.04
11420	Exc h-f-nk-sp b9+marg 0.5 <		T	0020	8.4929	$584.96	.	$117.00
11421	Exc h-f-nk-sp b9+marg 0.6-1		T	0020	8.4929	$584.96	.	$117.00
11422	Exc h-f-nk-sp b9+marg 1.1-2		T	0020	8.4929	$584.96	.	$117.00
11423	Exc h-f-nk-sp b9+marg 2.1-3		T	0021	18.0784	$1,245.17	.	$249.04
11424	Exc h-f-nk-sp b9+marg 3.1-4		T	0021	18.0784	$1,245.17	.	$249.04
11426	Exc h-f-nk-sp b9+marg > 4 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
11440	Exc face-mm b9+marg 0.5 < cm		T	0019	5.0887	$350.49	.	$70.10
11441	Exc face-mm b9+marg 0.6-1 cm		T	0019	5.0887	$350.49	.	$70.10
11442	Exc face-mm b9+marg 1.1-2 cm		T	0020	8.4929	$584.96	.	$117.00
11443	Exc face-mm b9+marg 2.1-3 cm		T	0020	8.4929	$584.96	.	$117.00
11444	Exc face-mm b9+marg 3.1-4 cm		T	0020	8.4929	$584.96	.	$117.00
11446	Exc face-mm b9+marg > 4 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
11450	Removal sweat gland lesion		T	0022	23.8986	$1,646.04	$354.45	$329.21
11451	Removal sweat gland lesion		T	0022	23.8986	$1,646.04	$354.45	$329.21
11462	Removal sweat gland lesion		T	0022	23.8986	$1,646.04	$354.45	$329.21
11463	Removal sweat gland lesion		T	0022	23.8986	$1,646.04	$354.45	$329.21

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11470	Removal sweat gland lesion		T	0022	23.8986	$1,646.04	$354.45	$329.21
11471	Removal sweat gland lesion		T	0022	23.8986	$1,646.04	$354.45	$329.21
11600	Exc tr-ext mlg+marg 0.5 < cm		T	0020	8.4929	$584.96	.	$117.00
11601	Exc tr-ext mlg+marg 0.6-1 cm		T	0019	5.0887	$350.49	.	$70.10
11602	Exc tr-ext mlg+marg 1.1-2 cm		T	0019	5.0887	$350.49	.	$70.10
11603	Exc tr-ext mlg+marg 2.1-3 cm		T	0020	8.4929	$584.96	.	$117.00
11604	Exc tr-ext mlg+marg 3.1-4 cm		T	0020	8.4929	$584.96	.	$117.00
11606	Exc tr-ext mlg+marg > 4 cm		T	0021	18.0784	$1,245.17	.	$249.04
11620	Exc h-f-nk-sp mlg+marg 0.5 <		T	0020	8.4929	$584.96	.	$117.00
11621	Exc h-f-nk-sp mlg+marg 0.6-1		T	0019	5.0887	$350.49	.	$70.10
11622	Exc h-f-nk-sp mlg+marg 1.1-2		T	0020	8.4929	$584.96	.	$117.00
11623	Exc h-f-nk-sp mlg+marg 2.1-3		T	0021	18.0784	$1,245.17	.	$249.04
11624	Exc h-f-nk-sp mlg+marg 3.1-4		T	0021	18.0784	$1,245.17	.	$249.04
11626	Exc h-f-nk-sp mlg+mar > 4 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
11640	Exc face-mm malig+marg 0.5 <	CH	T	0019	5.0887	$350.49	.	$70.10
11641	Exc face-mm malig+marg 0.6-1	CH	T	0019	5.0887	$350.49	.	$70.10
11642	Exc face-mm malig+marg 1.1-2	CH	T	0019	5.0887	$350.49	.	$70.10
11643	Exc face-mm malig+marg 2.1-3		T	0020	8.4929	$584.96	.	$117.00
11644	Exc face-mm malig+marg 3.1-4		T	0021	18.0784	$1,245.17	.	$249.04
11646	Exc face-mm mlg+marg > 4 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
11719	Trim nail(s)		T	0012	0.4326	$29.80	.	$5.96
11720	Debride nail 1-5		T	0013	0.9103	$62.70	.	$12.54
11721	Debride nail 6 or more		T	0013	0.9103	$62.70	.	$12.54
11730	Removal of nail plate		T	0013	0.9103	$62.70	.	$12.54
11732	Remove nail plate add-on		T	0013	0.9103	$62.70	.	$12.54
11740	Drain blood from under nail		T	0012	0.4326	$29.80	.	$5.96
11750	Removal of nail bed		T	0019	5.0887	$350.49	.	$70.10
11752	Remove nail bed/finger tip		T	0022	23.8986	$1,646.04	$354.45	$329.21
11755	Biopsy nail unit		T	0019	5.0887	$350.49	.	$70.10
11760	Repair of nail bed		T	0133	1.3330	$91.81	$25.67	$18.37
11762	Reconstruction of nail bed		T	0136	17.2117	$1,185.47	.	$237.10
11765	Excision of nail fold toe		T	0013	0.9103	$62.70	.	$12.54
11770	Removal of pilonidal lesion		T	0022	23.8986	$1,646.04	$354.45	$329.21
11771	Removal of pilonidal lesion		T	0022	23.8986	$1,646.04	$354.45	$329.21
11772	Removal of pilonidal lesion		T	0022	23.8986	$1,646.04	$354.45	$329.21
11900	Injection into skin lesions		T	0013	0.9103	$62.70	.	$12.54
11901	Added skin lesions injection		T	0013	0.9103	$62.70	.	$12.54
11920	Correct skin color defects		T	0134	3.1618	$217.77	.	$43.56
11921	Correct skin color defects		T	0134	3.1618	$217.77	.	$43.56

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11922	Correct skin color defects		T	0134	3.1618	$217.77	.	$43.56
11950	Therapy for contour defects		T	0133	1.3330	$91.81	$25.67	$18.37
11951	Therapy for contour defects		T	0133	1.3330	$91.81	$25.67	$18.37
11952	Therapy for contour defects		T	0133	1.3330	$91.81	$25.67	$18.37
11954	Therapy for contour defects		T	0133	1.3330	$91.81	$25.67	$18.37
11960	Insert tissue expander(s)		T	0137	22.2821	$1,534.70	.	$306.94
11970	Replace tissue expander		T	0051	47.3213	$3,259.30	.	$651.86
11971	Remove tissue expander(s)		T	0022	23.8986	$1,646.04	$354.45	$329.21
11975	Insert contraceptive cap		E					
11976	Removal of contraceptive cap		T	0019	5.0887	$350.49	.	$70.10
11977	Removal/reinsert contra cap		E					
11980	Implant hormone pellet(s)		X	0340	0.6712	$46.23	.	$9.25
11981	Insert drug implant device		X	0340	0.6712	$46.23	.	$9.25
11982	Remove drug implant device		X	0340	0.6712	$46.23	.	$9.25
11983	Remove/insert drug implant		X	0340	0.6712	$46.23	.	$9.25
12001	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12002	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12004	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12005	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12006	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12007	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12011	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12013	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12014	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12015	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12016	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12017	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12018	Repair superficial wound(s)		T	0133	1.3330	$91.81	$25.67	$18.37
12020	Closure of split wound		T	0135	4.6422	$319.74	.	$63.95
12021	Closure of split wound		T	0134	3.1618	$217.77	.	$43.56
12031	Intmd wnd repair s/tr/ext		T	0133	1.3330	$91.81	$25.67	$18.37
12032	Intmd wnd repair s/tr/ext		T	0134	3.1618	$217.77	.	$43.56
12034	Intmd wnd repair s/tr/ext		T	0133	1.3330	$91.81	$25.67	$18.37
12035	Intmd wnd repair s/tr/ext		T	0133	1.3330	$91.81	$25.67	$18.37
12036	Intmd wnd repair s/tr/ext		T	0134	3.1618	$217.77	.	$43.56
12037	Intmd wnd repair s/tr/ext		T	0134	3.1618	$217.77	.	$43.56
12041	Intmd wnd repair n-hf/genit		T	0133	1.3330	$91.81	$25.67	$18.37
12042	Intmd wnd repair n-hg/genit		T	0133	1.3330	$91.81	$25.67	$18.37
12044	Intmd wnd repair n-hg/genit		T	0133	1.3330	$91.81	$25.67	$18.37

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12045	Intmd wnd repair n-hg/genit		T	0134	3.1618	$217.77	.	$43.56
12046	Intmd wnd repair n-hg/genit		T	0134	3.1618	$217.77	.	$43.56
12047	Intmd wnd repair n-hg/genit		T	0134	3.1618	$217.77	.	$43.56
12051	Intmd wnd repair face/mm	CH	T	0134	3.1618	$217.77	.	$43.56
12052	Intmd wnd repair face/mm		T	0133	1.3330	$91.81	$25.67	$18.37
12053	Intmd wnd repair face/mm		T	0133	1.3330	$91.81	$25.67	$18.37
12054	Intmd wnd repair face/mm		T	0133	1.3330	$91.81	$25.67	$18.37
12055	Intmd wnd repair face/mm		T	0134	3.1618	$217.77	.	$43.56
12056	Intmd wnd repair face/mm		T	0134	3.1618	$217.77	.	$43.56
12057	Intmd wnd repair face/mm		T	0134	3.1618	$217.77	.	$43.56
13100	Repair of wound or lesion		T	0135	4.6422	$319.74	.	$63.95
13101	Repair of wound or lesion		T	0135	4.6422	$319.74	.	$63.95
13102	Repair wound/lesion add-on		T	0135	4.6422	$319.74	.	$63.95
13120	Repair of wound or lesion		T	0134	3.1618	$217.77	.	$43.56
13121	Repair of wound or lesion		T	0134	3.1618	$217.77	.	$43.56
13122	Repair wound/lesion add-on		T	0133	1.3330	$91.81	$25.67	$18.37
13131	Repair of wound or lesion		T	0134	3.1618	$217.77	.	$43.56
13132	Repair of wound or lesion		T	0135	4.6422	$319.74	.	$63.95
13133	Repair wound/lesion add-on		T	0134	3.1618	$217.77	.	$43.56
13150	Repair of wound or lesion		T	0135	4.6422	$319.74	.	$63.95
13151	Repair of wound or lesion		T	0135	4.6422	$319.74	.	$63.95
13152	Repair of wound or lesion		T	0135	4.6422	$319.74	.	$63.95
13153	Repair wound/lesion add-on		T	0134	3.1618	$217.77	.	$43.56
13160	Late closure of wound		T	0137	22.2821	$1,534.70	.	$306.94
14000	Skin tissue rearrangement		T	0136	17.2117	$1,185.47	.	$237.10
14001	Skin tissue rearrangement		T	0136	17.2117	$1,185.47	.	$237.10
14020	Skin tissue rearrangement		T	0136	17.2117	$1,185.47	.	$237.10
14021	Skin tissue rearrangement		T	0136	17.2117	$1,185.47	.	$237.10
14040	Skin tissue rearrangement		T	0136	17.2117	$1,185.47	.	$237.10
14041	Skin tissue rearrangement		T	0136	17.2117	$1,185.47	.	$237.10
14060	Skin tissue rearrangement		T	0136	17.2117	$1,185.47	.	$237.10
14061	Skin tissue rearrangement		T	0136	17.2117	$1,185.47	.	$237.10
14301	Skin tissue rearrangement		T	0137	22.2821	$1,534.70	.	$306.94
14302	Skin tissue rearrange add-on		T	0137	22.2821	$1,534.70	.	$306.94
14350	Skin tissue rearrangement		T	0137	22.2821	$1,534.70	.	$306.94
15002	Wound prep trk/arm/leg		T	0135	4.6422	$319.74	.	$63.95
15003	Wound prep addl 100 cm		T	0135	4.6422	$319.74	.	$63.95
15004	Wound prep f/n/hf/g		T	0135	4.6422	$319.74	.	$63.95
15005	Wnd prep f/n/hf/g addl cm		T	0135	4.6422	$319.74	.	$63.95

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15040	Harvest cultured skin graft		T	0134	3.1618	$217.77	.	$43.56
15050	Skin pinch graft		T	0135	4.6422	$319.74	.	$63.95
15100	Skin splt grft trnk/arm/leg		T	0137	22.2821	$1,534.70	.	$306.94
15101	Skin splt grft t/a/l add-on		T	0137	22.2821	$1,534.70	.	$306.94
15110	Epidrm autogrft trnk/arm/leg		T	0135	4.6422	$319.74	.	$63.95
15111	Epidrm autogrft t/a/l add-on		T	0135	4.6422	$319.74	.	$63.95
15115	Epidrm a-grft face/nck/hf/g		T	0135	4.6422	$319.74	.	$63.95
15116	Epidrm a-grft f/n/hf/g addl		T	0135	4.6422	$319.74	.	$63.95
15120	Skn splt a-grft fac/nck/hf/g		T	0137	22.2821	$1,534.70	.	$306.94
15121	Skn splt a-grft f/n/hf/g add		T	0137	22.2821	$1,534.70	.	$306.94
15130	Derm autograft trnk/arm/leg		T	0136	17.2117	$1,185.47	.	$237.10
15131	Derm autograft t/a/l add-on		T	0136	17.2117	$1,185.47	.	$237.10
15135	Derm autograft face/nck/ht/g		T	0136	17.2117	$1,185.47	.	$237.10
15136	Derm autograft f/n/hf/g add		T	0136	17.2117	$1,185.47	.	$237.10
15150	Cult epiderm grft t/arm/leg		T	0135	4.6422	$319.74	.	$63.95
15151	Cult epiderm grft t/a/l addl		T	0135	4.6422	$319.74	.	$63.95
15152	Cult epiderm graft t/a/l +%		T	0135	4.6422	$319.74	.	$63.95
15155	Cult epiderm graft f/n/hf/g		T	0135	4.6422	$319.74	.	$63.95
15156	Cult epidrm grft f/n/hfg add		T	0135	4.6422	$319.74	.	$63.95
15157	Cult epiderm grft f/n/hfg +%		T	0135	4.6422	$319.74	.	$63.95
15170	Acell graft trunk/arms/legs		T	0135	4.6422	$319.74	.	$63.95
15171	Acell graft t/arm/leg add-on		T	0134	3.1618	$217.77	.	$43.56
15175	Acellular graft f/n/hf/g		T	0135	4.6422	$319.74	.	$63.95
15176	Acell graft f/n/hf/g add-on		T	0135	4.6422	$319.74	.	$63.95
15200	Skin full graft trunk		T	0136	17.2117	$1,185.47	.	$237.10
15201	Skin full graft trunk add-on		T	0136	17.2117	$1,185.47	.	$237.10
15220	Skin full graft scip/arm/leg		T	0136	17.2117	$1,185.47	.	$237.10
15221	Skin full graft add-on		T	0135	4.6422	$319.74	.	$63.95
15240	Skin full grft face/genit/hf		T	0136	17.2117	$1,185.47	.	$237.10
15241	Skin full graft add-on		T	0135	4.6422	$319.74	.	$63.95
15260	Skin full graft een & lips		T	0136	17.2117	$1,185.47	.	$237.10
15261	Skin full graft add-on		T	0136	17.2117	$1,185.47	.	$237.10
15300	Apply skinallogrft t/arm/lg		T	0135	4.6422	$319.74	.	$63.95
15301	Apply sknallogrft t/a/l addl		T	0135	4.6422	$319.74	.	$63.95
15320	Apply skin allogrft f/n/hf/g		T	0135	4.6422	$319.74	.	$63.95
15321	Aply sknallogrft f/n/hfg add		T	0135	4.6422	$319.74	.	$63.95
15330	Aply acell alogrft t/arm/leg		T	0135	4.6422	$319.74	.	$63.95
15331	Aply acell grft t/a/l add-on		T	0135	4.6422	$319.74	.	$63.95
15335	Apply acell graft f/n/hf/g		T	0135	4.6422	$319.74	.	$63.95

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15336	Aply acell grft f/n/hf/g add		T	0135	4.6422	$319.74	.	$63.95
15340	Apply cult skin substitute		T	0134	3.1618	$217.77	.	$43.56
15341	Apply cult skin sub add-on		T	0134	3.1618	$217.77	.	$43.56
15360	Apply cult derm sub t/a/l		T	0134	3.1618	$217.77	.	$43.56
15361	Aply cult derm sub t/a/l add		T	0134	3.1618	$217.77	.	$43.56
15365	Apply cult derm sub f/n/hf/g		T	0134	3.1618	$217.77	.	$43.56
15366	Apply cult derm f/hf/g add		T	0134	3.1618	$217.77	.	$43.56
15400	Apply skin xenograft t/a/l		T	0135	4.6422	$319.74	.	$63.95
15401	Apply skn xenogrft t/a/l add		T	0135	4.6422	$319.74	.	$63.95
15420	Apply skin xgraft f/n/hf/g		T	0135	4.6422	$319.74	.	$63.95
15421	Apply skn xgrft f/n/hf/g add		T	0135	4.6422	$319.74	.	$63.95
15430	Apply acellular xenograft		T	0135	4.6422	$319.74	.	$63.95
15431	Apply acellular xgraft add		T	0135	4.6422	$319.74	.	$63.95
15570	Form skin pedicle flap		T	0137	22.2821	$1,534.70	.	$306.94
15572	Form skin pedicle flap		T	0137	22.2821	$1,534.70	.	$306.94
15574	Form skin pedicle flap		T	0137	22.2821	$1,534.70	.	$306.94
15576	Form skin pedicle flap		T	0137	22.2821	$1,534.70	.	$306.94
15600	Skin graft		T	0137	22.2821	$1,534.70	.	$306.94
15610	Skin graft		T	0137	22.2821	$1,534.70	.	$306.94
15620	Skin graft		T	0137	22.2821	$1,534.70	.	$306.94
15630	Skin graft		T	0137	22.2821	$1,534.70	.	$306.94
15650	Transfer skin pedicle flap		T	0137	22.2821	$1,534.70	.	$306.94
15731	Forehead flap w/vasc pedicle		T	0137	22.2821	$1,534.70	.	$306.94
15732	Muscle-skin graft head/neck		T	0137	22.2821	$1,534.70	.	$306.94
15734	Muscle-skin graft trunk		T	0137	22.2821	$1,534.70	.	$306.94
15736	Muscle-skin graft arm		T	0137	22.2821	$1,534.70	.	$306.94
15738	Muscle-skin graft leg		T	0137	22.2821	$1,534.70	.	$306.94
15740	Island pedicle flap graft		T	0136	17.2117	$1,185.47	.	$237.10
15750	Neurovascular pedicle graft		T	0137	22.2821	$1,534.70	.	$306.94
15756	Free myo/skin flap microvasc		C					
15757	Free skin flap microvasc		C					
15758	Free fascial flap microvasc		C					
15760	Composite skin graft		T	0137	22.2821	$1,534.70	.	$306.94
15770	Derma-fat-fascia graft		T	0137	22.2821	$1,534.70	.	$306.94
15775	Hair transplant punch grafts		T	0133	1.3330	$91.81	$25.67	$18.37
15776	Hair transplant punch grafts		T	0133	1.3330	$91.81	$25.67	$18.37
15780	Abrasion treatment of skin		T	0022	23.8986	$1,646.04	$354.45	$329.21
15781	Abrasion treatment of skin		T	0019	5.0887	$350.49	.	$70.10
15782	Abrasion treatment of skin		T	0019	5.0887	$350.49	.	$70.10

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15783	Abrasion treatment of skin		T	0016	2.7318	$188.16	.	$37.64
15786	Abrasion lesion single		T	0013	0.9103	$62.70	.	$12.54
15787	Abrasion lesions add-on		T	0013	0.9103	$62.70	.	$12.54
15788	Chemical peel face epiderm		T	0013	0.9103	$62.70	.	$12.54
15789	Chemical peel face dermal		T	0015	1.4975	$103.14	.	$20.63
15792	Chemical peel nonfacial		T	0015	1.4975	$103.14	.	$20.63
15793	Chemical peel nonfacial		T	0013	0.9103	$62.70	.	$12.54
15819	Plastic surgery neck		T	0134	3.1618	$217.77	.	$43.56
15820	Revision of lower eyelid		T	0137	22.2821	$1,534.70	.	$306.94
15821	Revision of lower eyelid		T	0137	22.2821	$1,534.70	.	$306.94
15822	Revision of upper eyelid		T	0137	22.2821	$1,534.70	.	$306.94
15823	Revision of upper eyelid		T	0137	22.2821	$1,534.70	.	$306.94
15824	Removal of forehead wrinkles		T	0137	22.2821	$1,534.70	.	$306.94
15825	Removal of neck wrinkles		T	0137	22.2821	$1,534.70	.	$306.94
15826	Removal of brow wrinkles		T	0137	22.2821	$1,534.70	.	$306.94
15828	Removal of face wrinkles		T	0137	22.2821	$1,534.70	.	$306.94
15829	Removal of skin wrinkles		T	0137	22.2821	$1,534.70	.	$306.94
15830	Exc skin abd		T	0022	23.8986	$1,646.04	$354.45	$329.21
15832	Excise excessive skin tissue		T	0022	23.8986	$1,646.04	$354.45	$329.21
15833	Excise excessive skin tissue		T	0022	23.8986	$1,646.04	$354.45	$329.21
15834	Excise excessive skin tissue		T	0022	23.8986	$1,646.04	$354.45	$329.21
15835	Excise excessive skin tissue		T	0022	23.8986	$1,646.04	$354.45	$329.21
15836	Excise excessive skin tissue		T	0021	18.0784	$1,245.17	.	$249.04
15837	Excise excessive skin tissue		T	0021	18.0784	$1,245.17	.	$249.04
15838	Excise excessive skin tissue		T	0021	18.0784	$1,245.17	.	$249.04
15839	Excise excessive skin tissue		T	0021	18.0784	$1,245.17	.	$249.04
15840	Graft for face nerve palsy		T	0137	22.2821	$1,534.70	.	$306.94
15841	Graft for face nerve palsy		T	0137	22.2821	$1,534.70	.	$306.94
15842	Flap for face nerve palsy		T	0137	22.2821	$1,534.70	.	$306.94
15845	Skin and muscle repair face		T	0137	22.2821	$1,534.70	.	$306.94
15847	Exc skin abd add-on		T	0022	23.8986	$1,646.04	$354.45	$329.21
15850	Removal of sutures		T	0016	2.7318	$188.16	.	$37.64
15851	Removal of sutures		T	0016	2.7318	$188.16	.	$37.64
15852	Dressing change not for burn		X	0340	0.6712	$46.23	.	$9.25
15860	Test for blood flow in graft		X	0340	0.6712	$46.23	.	$9.25
15876	Suction assisted lipectomy		T	0137	22.2821	$1,534.70	.	$306.94
15877	Suction assisted lipectomy		T	0137	22.2821	$1,534.70	.	$306.94
15878	Suction assisted lipectomy		T	0137	22.2821	$1,534.70	.	$306.94
15879	Suction assisted lipectomy		T	0137	22.2821	$1,534.70	.	$306.94

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15920	Removal of tail bone ulcer		T	0019	5.0887	$350.49	.	$70.10
15922	Removal of tail bone ulcer		T	0137	22.2821	$1,534.70	.	$306.94
15931	Remove sacrum pressure sore		T	0022	23.8986	$1,646.04	$354.45	$329.21
15933	Remove sacrum pressure sore		T	0022	23.8986	$1,646.04	$354.45	$329.21
15934	Remove sacrum pressure sore		T	0137	22.2821	$1,534.70	.	$306.94
15935	Remove sacrum pressure sore		T	0137	22.2821	$1,534.70	.	$306.94
15936	Remove sacrum pressure sore		T	0136	17.2117	$1,185.47	.	$237.10
15937	Remove sacrum pressure sore		T	0137	22.2821	$1,534.70	.	$306.94
15940	Remove hip pressure sore		T	0022	23.8986	$1,646.04	$354.45	$329.21
15941	Remove hip pressure sore		T	0022	23.8986	$1,646.04	$354.45	$329.21
15944	Remove hip pressure sore		T	0137	22.2821	$1,534.70	.	$306.94
15945	Remove hip pressure sore		T	0137	22.2821	$1,534.70	.	$306.94
15946	Remove hip pressure sore		T	0137	22.2821	$1,534.70	.	$306.94
15950	Remove thigh pressure sore		T	0022	23.8986	$1,646.04	$354.45	$329.21
15951	Remove thigh pressure sore		T	0022	23.8986	$1,646.04	$354.45	$329.21
15952	Remove thigh pressure sore		T	0136	17.2117	$1,185.47	.	$237.10
15953	Remove thigh pressure sore		T	0136	17.2117	$1,185.47	.	$237.10
15956	Remove thigh pressure sore		T	0136	17.2117	$1,185.47	.	$237.10
15958	Remove thigh pressure sore		T	0136	17.2117	$1,185.47	.	$237.10
15999	Removal of pressure sore		T	0019	5.0887	$350.49	.	$70.10
16000	Initial treatment of burn(s)		T	0013	0.9103	$62.70	.	$12.54
16020	Dress/debrid p-thick burn s		T	0015	1.4975	$103.14	.	$20.63
16025	Dress/debrid p-thick burn m		T	0015	1.4975	$103.14	.	$20.63
16030	Dress/debrid p-thick burn l		T	0015	1.4975	$103.14	.	$20.63
16035	Incision of burn scab initi		T	0015	1.4975	$103.14	.	$20.63
16036	Escharotomy addl incision		C					
17000	Destruct premalg lesion		T	0013	0.9103	$62.70	.	$12.54
17003	Destruct premalg les 2-14		T	0012	0.4326	$29.80	.	$5.96
17004	Destroy premlg lesions 15+		T	0016	2.7318	$188.16	.	$37.64
17106	Destruction of skin lesions		T	0016	2.7318	$188.16	.	$37.64
17107	Destruction of skin lesions		T	0016	2.7318	$188.16	.	$37.64
17108	Destruction of skin lesions		T	0016	2.7318	$188.16	.	$37.64
17110	Destruct b9 lesion 1-14		T	0013	0.9103	$62.70	.	$12.54
17111	Destruct lesion 15 or more		T	0015	1.4975	$103.14	.	$20.63
17250	Chemical cautery tissue		T	0015	1.4975	$103.14	.	$20.63
17260	Destruction of skin lesions		T	0015	1.4975	$103.14	.	$20.63
17261	Destruction of skin lesions		T	0015	1.4975	$103.14	.	$20.63
17262	Destruction of skin lesions		T	0015	1.4975	$103.14	.	$20.63
17263	Destruction of skin lesions		T	0015	1.4975	$103.14	.	$20.63

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
17264	Destruction of skin lesions		T	0015	1.4975	$103.14	.	$20.63
17266	Destruction of skin lesions		T	0016	2.7318	$188.16	.	$37.64
17270	Destruction of skin lesions		T	0015	1.4975	$103.14	.	$20.63
17271	Destruction of skin lesions		T	0015	1.4975	$103.14	.	$20.63
17272	Destruction of skin lesions		T	0015	1.4975	$103.14	.	$20.63
17273	Destruction of skin lesions		T	0016	2.7318	$188.16	.	$37.64
17274	Destruction of skin lesions		T	0016	2.7318	$188.16	.	$37.64
17276	Destruction of skin lesions		T	0016	2.7318	$188.16	.	$37.64
17280	Destruction of skin lesions		T	0015	1.4975	$103.14	.	$20.63
17281	Destruction of skin lesions		T	0016	2.7318	$188.16	.	$37.64
17282	Destruction of skin lesions		T	0016	2.7318	$188.16	.	$37.64
17283	Destruction of skin lesions		T	0016	2.7318	$188.16	.	$37.64
17284	Destruction of skin lesions		T	0016	2.7318	$188.16	.	$37.64
17286	Destruction of skin lesions		T	0016	2.7318	$188.16	.	$37.64
17311	Mohs 1 stage h/n/hf/g		T	0694	5.3665	$369.62	$91.69	$73.93
17312	Mohs addl stage		T	0694	5.3665	$369.62	$91.69	$73.93
17313	Mohs 1 stage t/a/l		T	0694	5.3665	$369.62	$91.69	$73.93
17314	Mohs addl stage t/a/l		T	0694	5.3665	$369.62	$91.69	$73.93
17315	Mohs surg addl block		T	0694	5.3665	$369.62	$91.69	$73.93
17340	Cryotherapy of skin		T	0013	0.9103	$62.70	.	$12.54
17360	Skin peel therapy		T	0013	0.9103	$62.70	.	$12.54
17380	Hair removal by electrolysis		T	0013	0.9103	$62.70	.	$12.54
17999	Skin tissue procedure		T	0012	0.4326	$29.80	.	$5.96
19000	Drainage of breast lesion		T	0004	4.5843	$315.75	.	$63.15
19001	Drain breast lesion add-on		T	0002	1.5703	$108.16	.	$21.64
19020	Incision of breast lesion		T	0008	20.1996	$1,391.27	.	$278.26
19030	Injection for breast x-ray		N					
19100	Bx breast percut w/o image		T	0004	4.5843	$315.75	.	$63.15
19101	Biopsy of breast open		T	0028	25.5910	$1,762.61	.	$352.53
19102	Bx breast percut w/image		T	0005	8.1362	$560.39	.	$112.08
19103	Bx breast percut w/device		T	0037	15.7009	$1,081.42	$228.76	$216.29
19105	Cryosurg ablate fa each		T	0029	33.9253	$2,336.64	$581.52	$467.33
19110	Nipple exploration		T	0028	25.5910	$1,762.61	.	$352.53
19112	Excise breast duct fistula		T	0028	25.5910	$1,762.61	.	$352.53
19120	Removal of breast lesion		T	0028	25.5910	$1,762.61	.	$352.53
19125	Excision breast lesion		T	0028	25.5910	$1,762.61	.	$352.53
19126	Excision addl breast lesion		T	0028	25.5910	$1,762.61	.	$352.53
19260	Removal of chest wall lesion		T	0021	18.0784	$1,245.17	.	$249.04
19271	Revision of chest wall		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
19272	Extensive chest wall surgery		C					
19290	Place needle wire breast		N					
19291	Place needle wire breast		N					
19295	Place breast clip percut	CH	Q1	0340	0.6712	$46.23	.	$9.25
19296	Place po breast cath for rad		T	0648	63.9911	$4,407.45	.	$881.49
19297	Place breast cath for rad		T	0648	63.9911	$4,407.45	.	$881.49
19298	Place breast rad tube/caths		T	0648	63.9911	$4,407.45	.	$881.49
19300	Removal of breast tissue		T	0028	25.5910	$1,762.61	.	$352.53
19301	Partical mastectomy		T	0028	25.5910	$1,762.61	.	$352.53
19302	P-mastectomy w/ln removal		T	0030	45.0028	$3,099.61	$747.07	$619.93
19303	Mast simple complete		T	0029	33.9253	$2,336.64	$581.52	$467.33
19304	Mast subq		T	0029	33.9253	$2,336.64	$581.52	$467.33
19305	Mast radical		C					
19306	Mast rad urban type		C					
19307	Mast mod rad		T	0030	45.0028	$3,099.61	$747.07	$619.93
19316	Suspension of breast		T	0029	33.9253	$2,336.64	$581.52	$467.33
19318	Reduction of large breast		T	0030	45.0028	$3,099.61	$747.07	$619.93
19324	Enlarge breast		T	0030	45.0028	$3,099.61	$747.07	$619.93
19325	Enlarge breast with implant		T	0648	63.9911	$4,407.45	.	$881.49
19328	Removal of breast implant		T	0029	33.9253	$2,336.64	$581.52	$467.33
19330	Removal of implant material		T	0029	33.9253	$2,336.64	$581.52	$467.33
19340	Immediate breast prosthesis		T	0030	45.0028	$3,099.61	$747.07	$619.93
19342	Delayed breast prosthesis		T	0648	63.9911	$4,407.45	.	$881.49
19350	Breast reconstruction		T	0028	25.5910	$1,762.61	.	$352.53
19355	Correct inverted nipple(s)		T	0029	33.9253	$2,336.64	$581.52	$467.33
19357	Breast reconstruction		T	0648	63.9911	$4,407.45	.	$881.49
19361	Breast reconstr w/lat flap		C					
19364	Breast reconstruction		C					
19366	Breast reconstruction		T	0029	33.9253	$2,336.64	$581.52	$467.33
19367	Breast reconstruction		C					
19368	Breast reconstruction		C					
19369	Breast reconstruction		C					
19370	Surgery of breast capsule		T	0029	33.9253	$2,336.64	$581.52	$467.33
19371	Removal of breast capsule		T	0029	33.9253	$2,336.64	$581.52	$467.33
19380	Revise breast reconstruction		T	0030	45.0028	$3,099.61	$747.07	$619.93
19396	Design custom breast implant		T	0029	33.9253	$2,336.64	$581.52	$467.33
19499	Breast surgery procedure		T	0028	25.5910	$1,762.61	.	$352.53
20000	Incision of abscess	CH	D					
20005	I&d abscess subfascial	NI	T	0020	8.4929	$584.96	.	$117.00

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20100	Explore wound neck		T	0252	7.9194	$545.46	$109.16	$109.10
20101	Explore wound chest		T	0137	22.2821	$1,534.70	.	$306.94
20102	Explore wound abdomen		T	0137	22.2821	$1,534.70	.	$306.94
20103	Explore wound extremity		T	0007	13.0129	$896.28	.	$179.26
20150	Excise epiphyseal bar		T	0051	47.3213	$3,259.30	.	$651.86
20200	Muscle biopsy		T	0021	18.0784	$1,245.17	.	$249.04
20205	Deep muscle biopsy		T	0021	18.0784	$1,245.17	.	$249.04
20206	Needle biopsy muscle		T	0005	8.1362	$560.39	.	$112.08
20220	Bone biopsy trocar/needle		T	0020	8.4929	$584.96	.	$117.00
20225	Bone biopsy trocar/needle		T	0021	18.0784	$1,245.17	.	$249.04
20240	Bone biopsy excisional		T	0022	23.8986	$1,646.04	$354.45	$329.21
20245	Bone biopsy excisional		T	0022	23.8986	$1,646.04	$354.45	$329.21
20250	Open bone biopsy		T	0049	22.9744	$1,582.38	.	$316.48
20251	Open bone biopsy		T	0049	22.9744	$1,582.38	.	$316.48
20500	Injection of sinus tract		T	0252	7.9194	$545.46	$109.16	$109.10
20501	Inject sinus tract for x-ray		N					
20520	Removal of foreign body		T	0019	5.0887	$350.49	.	$70.10
20525	Removal of foreign body		T	0022	23.8986	$1,646.04	$354.45	$329.21
20526	Ther injection carp tunnel		T	0204	2.6683	$183.78	$40.13	$36.76
20550	Inj tendon sheath/ligament		T	0204	2.6683	$183.78	$40.13	$36.76
20551	Inj tendon origin/insertion		T	0204	2.6683	$183.78	$40.13	$36.76
20552	Inj trigger point 1/2 muscl		T	0204	2.6683	$183.78	$40.13	$36.76
20553	Inject trigger points =/> 3		T	0204	2.6683	$183.78	$40.13	$36.76
20555	Place ndl musc/tis for rt		T	0050	32.2439	$2,220.83	.	$444.17
20600	Drain/inject joint/bursa		T	0204	2.6683	$183.78	$40.13	$36.76
20605	Drain/inject joint/bursa		T	0204	2.6683	$183.78	$40.13	$36.76
20610	Drain/inject joint/bursa		T	0204	2.6683	$183.78	$40.13	$36.76
20612	Aspirate/inj ganglion cyst		T	0204	2.6683	$183.78	$40.13	$36.76
20615	Treatment of bone cyst		T	0004	4.5843	$315.75	.	$63.15
20650	Insert and remove bone pin		T	0049	22.9744	$1,582.38	.	$316.48
20660	Apply rem fixation device		T	0138	5.5050	$379.16	.	$75.84
20661	Application of head brace		C					
20662	Application of pelvis brace		T	0049	22.9744	$1,582.38	.	$316.48
20663	Application of thigh brace		T	0049	22.9744	$1,582.38	.	$316.48
20664	Application of halo		C					
20665	Removal of fixation device		X	0340	0.6712	$46.23	.	$9.25
20670	Removal of support implant		T	0021	18.0784	$1,245.17	.	$249.04
20680	Removal of support implant		T	0022	23.8986	$1,646.04	$354.45	$329.21
20690	Apply bone fixation device		T	0050	32.2439	$2,220.83	.	$444.17

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20692	Apply bone fixation device		T	0050	32.2439	$2,220.83	.	$444.17
20693	Adjust bone fixation device		T	0049	22.9744	$1,582.38	.	$316.48
20694	Remove bone fixation device		T	0049	22.9744	$1,582.38	.	$316.48
20696	Comp multiplane ext fixation		T	0050	32.2439	$2,220.83	.	$444.17
20697	Comp ext fixate strut change		T	0139	20.8356	$1,435.07	.	$287.02
20802	Replantation arm complete		C					
20805	Replant forearm complete		C					
20808	Replantation hand complete		C					
20816	Replantation digit complete		C					
20822	Replantation digit complete		T	0054	29.7686	$2,050.34	.	$410.07
20824	Replantation thumb complete		C					
20827	Replantation thumb complete		C					
20838	Replantation foot complete		C					
20900	Removal of bone for graft		T	0050	32.2439	$2,220.83	.	$444.17
20902	Removal of bone for graft		T	0050	32.2439	$2,220.83	.	$444.17
20910	Remove cartilage for graft		T	0137	22.2821	$1,534.70	.	$306.94
20912	Remove cartilage for graft		T	0137	22.2821	$1,534.70	.	$306.94
20920	Removal of fascia for graft		T	0136	17.2117	$1,185.47	.	$237.10
20922	Removal of fascia for graft		T	0136	17.2117	$1,185.47	.	$237.10
20924	Removal of tendon for graft		T	0050	32.2439	$2,220.83	.	$444.17
20926	Removal of tissue for graft		T	0135	4.6422	$319.74	.	$63.95
20930	Sp bone algrft morsel add-on	NI	C					
20931	Sp bone algrft struct add-on		C					
20936	Sp bone agrft local add-on		C					
20937	Sp bone agrft morsel add-on		C					
20938	Sp bone agrft struct add-on		C					
20950	Fluid pressure muscle		T	0006	1.4906	$102.67	.	$20.54
20955	Fibula bone graft microvasc		C					
20956	Iliac bone graft microvasc		C					
20957	Mt bone graft microvasc		C					
20962	Other bone graft microvasc		C					
20969	Bone/skin graft microvasc		C					
20970	Bone/skin graft iliac crest		C					
20972	Bone/skin graft metatarsal		T	0056	55.2578	$3,805.94	.	$761.19
20973	Bone/skin graft great toe		T	0056	55.2578	$3,805.94	.	$761.19
20974	Electrical bone stimulation		A					
20975	Electrical bone stimulation		N					
20979	Us bone stimulation		X	0340	0.6712	$46.23	.	$9.25
20982	Ablate bone tumor(s) perq		T	0051	47.3213	$3,259.30	.	$651.86

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20985	Cptr-asst dir ms px		N					
20999	Musculoskeletal surgery		T	0049	22.9744	$1,582.38	.	$316.48
21010	Incision of jaw joint		T	0254	25.6472	$1,766.48	.	$353.30
21011	Exc face les sc < 2 cm		T	0020	8.4929	$584.96	.	$117.00
21012	Exc face les sbq 2+ cm		T	0020	8.4929	$584.96	.	$117.00
21013	Exc face tum deep < 2 cm		T	0020	8.4929	$584.96	.	$117.00
21014	Exc face tum deep 2+ cm		T	0020	8.4929	$584.96	.	$117.00
21015	Resect face tum < 2 cm		T	0021	18.0784	$1,245.17	.	$249.04
21016	Resect face tum + cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
21025	Excision of bone lower jaw		T	0256	44.6899	$3,078.06	.	$615.62
21026	Excision of facial bone(s)		T	0256	44.6899	$3,078.06	.	$615.62
21029	Contour of face bone lesion		T	0256	44.6899	$3,078.06	.	$615.62
21030	Excise max/zygoma b9 tumor		T	0254	25.6472	$1,766.48	.	$353.30
21031	Remove exostosis mandible		T	0254	25.6472	$1,766.48	.	$353.30
21032	Remove exostosis maxilla		T	0254	25.6472	$1,766.48	.	$353.30
21034	Excise max/zygoma mlg tumor		T	0256	44.6899	$3,078.06	.	$615.62
21040	Excise mandible lesion		T	0254	25.6472	$1,766.48	.	$353.30
21044	Removal of jaw bone lesion		T	0256	44.6899	$3,078.06	.	$615.62
21045	Extensive jaw surgery		C					
21046	Remove mandible cyst complex		T	0256	44.6899	$3,078.06	.	$615.62
21047	Excise lwr jaw cyst w/repair		T	0256	44.6899	$3,078.06	.	$615.62
21048	Remove maxilla cyst complex		T	0256	44.6899	$3,078.06	.	$615.62
21049	Excis uppr jaw cyst w/repair		T	0256	44.6899	$3,078.06	.	$615.62
21050	Removal of jaw joint		T	0256	44.6899	$3,078.06	.	$615.62
21060	Remove jaw joint cartilage		T	0256	44.6899	$3,078.06	.	$615.62
21070	Remove coronoid process		T	0256	44.6899	$3,078.06	.	$615.62
21073	Mnpj of tmj w/anesth		T	0252	7.9194	$545.46	$109.16	$109.10
21076	Prepare face/oral prosthesis		T	0254	25.6472	$1,766.48	.	$353.30
21077	Prepare face/oral prosthesis		T	0256	44.6899	$3,078.06	.	$615.62
21079	Prepare face/oral prosthesis		T	0256	44.6899	$3,078.06	.	$615.62
21080	Prepare face/oral prosthesis		T	0256	44.6899	$3,078.06	.	$615.62
21081	Prepare face/oral prosthesis		T	0256	44.6899	$3,078.06	.	$615.62
21082	Prepare face/oral prosthesis		T	0256	44.6899	$3,078.06	.	$615.62
21083	Prepare face/oral prosthesis		T	0256	44.6899	$3,078.06	.	$615.62
21084	Prepare face/oral prosthesis		T	0256	44.6899	$3,078.06	.	$615.62
21085	Prepare face/oral prosthesis		T	0253	17.3388	$1,194.23	$282.29	$238.85
21086	Prepare face/oral prosthesis		T	0256	44.6899	$3,078.06	.	$615.62
21087	Prepare face/oral prosthesis		T	0256	44.6899	$3,078.06	.	$615.62

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21088	Prepare face/oral prosthesis		T	0256	44.6899	$3,078.06	.	$615.62
21089	Prepare face/oral prosthesis		T	0250	1.1331	$78.04	$25.10	$15.61
21100	Maxillofacial fixation		T	0256	44.6899	$3,078.06	.	$615.62
21110	Interdental fixation		T	0252	7.9194	$545.46	$109.16	$109.10
21116	Injection jaw joint x-ray		N					
21120	Reconstruction of chin		T	0254	25.6472	$1,766.48	.	$353.30
21121	Reconstruction of chin		T	0254	25.6472	$1,766.48	.	$353.30
21122	Reconstruction of chin		T	0254	25.6472	$1,766.48	.	$353.30
21123	Reconstruction of chin		T	0254	25.6472	$1,766.48	.	$353.30
21125	Augmentation lower jaw bone		T	0254	25.6472	$1,766.48	.	$353.30
21127	Augmentation lower jaw bone		T	0256	44.6899	$3,078.06	.	$615.62
21137	Reduction of forehead		T	0254	25.6472	$1,766.48	.	$353.30
21138	Reduction of forehead		T	0256	44.6899	$3,078.06	.	$615.62
21139	Reduction of forehead		T	0256	44.6899	$3,078.06	.	$615.62
21141	Reconstruct midface lefort		C					
21142	Reconstruct midface lefort		C					
21143	Reconstruct midface lefort		C					
21145	Reconstruct midface lefort		C					
21146	Reconstruct midface lefort		C					
21147	Reconstruct midface lefort		C					
21150	Reconstruct midface lefort		T	0256	44.6899	$3,078.06	.	$615.62
21151	Reconstruct midface lefort		C					
21154	Reconstruct midface lefort		C					
21155	Reconstruct midface lefort		C					
21159	Reconstruct midface lefort		C					
21160	Reconstruct midface lefort		C					
21172	Reconstruct orbit/forehead		T	0256	44.6899	$3,078.06	.	$615.62
21175	Reconstruct orbit/forehead		T	0256	44.6899	$3,078.06	.	$615.62
21179	Reconstruct entire forehead		C					
21180	Reconstruct entire forehead		C					
21181	Contour cranial bone lesion		T	0254	25.6472	$1,766.48	.	$353.30
21182	Reconstruct cranial bone		C					
21183	Reconstruct cranial bone		C					
21184	Reconstruct cranial bone		C					
21188	Reconstruction of midface		C					
21193	Reconst lwr jaw w/o graft	CH	T	0256	44.6899	$3,078.06	.	$615.62
21194	Reconst lwr jaw w/graft		C					
21195	Reconst lwr jaw w/o fixation		T	0256	44.6899	$3,078.06	.	$615.62
21196	Reconst lwr jaw w/fixation		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21198	Reconstr lwr jaw segment		T	0256	44.6899	$3,078.06	.	$615.62
21199	Reconstr lwr jaw w/advance		T	0256	44.6899	$3,078.06	.	$615.62
21206	Reconstruct upper jaw bone		T	0256	44.6899	$3,078.06	.	$615.62
21208	Augmentation of facial bones		T	0256	44.6899	$3,078.06	.	$615.62
21209	Reduction of facial bones		T	0256	44.6899	$3,078.06	.	$615.62
21210	Face bone graft		T	0256	44.6899	$3,078.06	.	$615.62
21215	Lower jaw bone graft		T	0256	44.6899	$3,078.06	.	$615.62
21230	Rib cartilage graft		T	0256	44.6899	$3,078.06	.	$615.62
21235	Ear cartilage graft		T	0254	25.6472	$1,766.48	.	$353.30
21240	Reconstruction of jaw joint		T	0256	44.6899	$3,078.06	.	$615.62
21242	Reconstruction of jaw joint		T	0256	44.6899	$3,078.06	.	$615.62
21243	Reconstruction of jaw joint		T	0256	44.6899	$3,078.06	.	$615.62
21244	Reconstruction of lower jaw		T	0256	44.6899	$3,078.06	.	$615.62
21245	Reconstruction of jaw		T	0256	44.6899	$3,078.06	.	$615.62
21246	Reconstruction of jaw		T	0256	44.6899	$3,078.06	.	$615.62
21247	Reconstruct lower jaw bone		C					
21248	Reconstruction of jaw		T	0256	44.6899	$3,078.06	.	$615.62
21249	Reconstruction of jaw		T	0256	44.6899	$3,078.06	.	$615.62
21255	Reconstruct lower jaw bone		C					
21256	Reconstruction of orbit		T	0256	44.6899	$3,078.06	.	$615.62
21260	Revise eye sockets		T	0256	44.6899	$3,078.06	.	$615.62
21261	Revise eye sockets		T	0256	44.6899	$3,078.06	.	$615.62
21263	Revise eye sockets		T	0256	44.6899	$3,078.06	.	$615.62
21267	Revise eye sockets		T	0256	44.6899	$3,078.06	.	$615.62
21268	Revise eye sockets		C					
21270	Augmentation cheek bone		T	0256	44.6899	$3,078.06	.	$615.62
21275	Revision orbitofacial bones		T	0256	44.6899	$3,078.06	.	$615.62
21280	Revision of eyelid		T	0256	44.6899	$3,078.06	.	$615.62
21282	Revision of eyelid		T	0253	17.3388	$1,194.23	$282.29	$238.85
21295	Revision of jaw muscle/bone		T	0252	7.9194	$545.46	$109.16	$109.10
21296	Revision of jaw muscle/bone		T	0254	25.6472	$1,766.48	.	$353.30
21299	Cranio/maxillofacial surgery		T	0250	1.1331	$78.04	$25.10	$15.61
21310	Treatment of nose fracture		T	0250	1.1331	$78.04	$25.10	$15.61
21315	Treatment of nose fracture		T	0253	17.3388	$1,194.23	$282.29	$238.85
21320	Treatment of nose fracture		T	0253	17.3388	$1,194.23	$282.29	$238.85
21325	Treatment of nose fracture		T	0254	25.6472	$1,766.48	.	$353.30
21330	Treatment of nose fracture		T	0254	25.6472	$1,766.48	.	$353.30
21335	Treatment of nose fracture		T	0254	25.6472	$1,766.48	.	$353.30
21336	Treat nasal septal fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21337	Treat nasal septal fracture		T	0253	17.3388	$1,194.23	$282.29	$238.85
21338	Treat nasoethmoid fracture		T	0254	25.6472	$1,766.48	.	$353.30
21339	Treat nasoethmoid fracture		T	0254	25.6472	$1,766.48	.	$353.30
21340	Treatment of nose fracture		T	0256	44.6899	$3,078.06	.	$615.62
21343	Treatment of sinus fracture		C					
21344	Treatment of sinus fracture		C					
21345	Treat nose/jaw fracture		T	0254	25.6472	$1,766.48	.	$353.30
21346	Treat nose/jaw fracture		C					
21347	Treat nose/jaw fracture		C					
21348	Treat nose/jaw fracture		C					
21355	Treat cheek bone fracture		T	0256	44.6899	$3,078.06	.	$615.62
21356	Treat cheek bone fracture		T	0254	25.6472	$1,766.48	.	$353.30
21360	Treat cheek bone fracture		T	0254	25.6472	$1,766.48	.	$353.30
21365	Treat cheek bone fracture		T	0256	44.6899	$3,078.06	.	$615.62
21366	Treat cheek bone fracture		C					
21385	Treat eye socket fracture		T	0256	44.6899	$3,078.06	.	$615.62
21386	Treat eye socket fracture		T	0256	44.6899	$3,078.06	.	$615.62
21387	Treat eye socket fracture		T	0256	44.6899	$3,078.06	.	$615.62
21390	Treat eye socket fracture		T	0256	44.6899	$3,078.06	.	$615.62
21395	Treat eye socket fracture	CH	T	0256	44.6899	$3,078.06	.	$615.62
21400	Treat eye socket fracture		T	0252	7.9194	$545.46	$109.16	$109.10
21401	Treat eye socket fracture		T	0253	17.3388	$1,194.23	$282.29	$238.85
21406	Treat eye socket fracture		T	0256	44.6899	$3,078.06	.	$615.62
21407	Treat eye socket fracture		T	0256	44.6899	$3,078.06	.	$615.62
21408	Treat eye socket fracture		T	0256	44.6899	$3,078.06	.	$615.62
21421	Treat mouth roof fracture		T	0254	25.6472	$1,766.48	.	$353.30
21422	Treat mouth roof fracture		C					
21423	Treat mouth roof fracture		C					
21431	Treat craniofacial fracture		C					
21432	Treat craniofacial fracture		C					
21433	Treat craniofacial fracture		C					
21435	Treat craniofacial fracture		C					
21436	Treat craniofacial fracture		C					
21440	Treat dental ridge fracture		T	0254	25.6472	$1,766.48	.	$353.30
21445	Treat dental ridge fracture		T	0254	25.6472	$1,766.48	.	$353.30
21450	Treat lower jaw fracture		T	0251	3.5538	$244.77	.	$48.96
21451	Treat lower jaw fracture		T	0252	7.9194	$545.46	$109.16	$109.10
21452	Treat lower jaw fracture		T	0253	17.3388	$1,194.23	$282.29	$238.85
21453	Treat lower jaw fracture		T	0256	44.6899	$3,078.06	.	$615.62

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21454	Treat lower jaw fracture		T	0254	25.6472	$1,766.48	.	$353.30
21461	Treat lower jaw fracture		T	0256	44.6899	$3,078.06	.	$615.62
21462	Treat lower jaw fracture		T	0256	44.6899	$3,078.06	.	$615.62
21465	Treat lower jaw fracture		T	0256	44.6899	$3,078.06	.	$615.62
21470	Treat lower jaw fracture		T	0256	44.6899	$3,078.06	.	$615.62
21480	Reset dislocated jaw		T	0250	1.1331	$78.04	$25.10	$15.61
21485	Reset dislocated jaw		T	0253	17.3388	$1,194.23	$282.29	$238.85
21490	Repair dislocated jaw		T	0256	44.6899	$3,078.06	.	$615.62
21495	Treat hyoid bone fracture		T	0253	17.3388	$1,194.23	$282.29	$238.85
21497	Interdental wiring		T	0253	17.3388	$1,194.23	$282.29	$238.85
21499	Head surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61
21501	Drain neck/chest lesion		T	0008	20.1996	$1,391.27	.	$278.26
21502	Drain chest lesion		T	0049	22.9744	$1,582.38	.	$316.48
21510	Drainage of bone lesion		C					
21550	Biopsy of neck/chest		T	0021	18.0784	$1,245.17	.	$249.04
21552	Exc neck les sc 3+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
21554	Exc neck tum deep 5+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
21555	Exc neck les sc < 3 cm		T	0021	18.0784	$1,245.17	.	$249.04
21556	Exc neck tum deep < 5 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
21557	Resect neck tum < 5 cm		T	0021	18.0784	$1,245.17	.	$249.04
21558	Resect neck tum 5+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
21600	Partial removal of rib		T	0050	32.2439	$2,220.83	.	$444.17
21610	Partial removal of rib		T	0050	32.2439	$2,220.83	.	$444.17
21615	Removal of rib		C					
21616	Removal of rib and nerves		C					
21620	Partial removal of sternum		C					
21627	Sternal debridement		C					
21630	Extensive sternum surgery		C					
21632	Extensive sternum surgery		C					
21685	Hyoid myotomy & suspension		T	0252	7.9194	$545.46	$109.16	$109.10
21700	Revision of neck muscle		T	0049	22.9744	$1,582.38	.	$316.48
21705	Revision of neck muscle/rib		C					
21720	Revision of neck muscle		T	0049	22.9744	$1,582.38	.	$316.48
21725	Revision of neck muscle		T	0006	1.4906	$102.67	.	$20.54
21740	Reconstruction of sternum		C					
21742	Repair stern/nuss w/o scope		T	0051	47.3213	$3,259.30	.	$651.86
21743	Repair sternum/nuss w/scope		T	0051	47.3213	$3,259.30	.	$651.86
21750	Repair of sternum separation		C					
21800	Treatment of rib fracture		T	0129	1.5787	$108.73	.	$21.75

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21805	Treatment of rib fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
21810	Treatment of rib fracture(s)		C					
21820	Treat sternum fracture		T	0129	1.5787	$108.73	.	$21.75
21825	Treat sternum fracture		C					
21899	Neck/chest surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61
21920	Biopsy soft tissue of back		T	0020	8.4929	$584.96	.	$117.00
21925	Biopsy soft tissue of back		T	0022	23.8986	$1,646.04	$354.45	$329.21
21930	Exc back les sc < 3 cm		T	0021	18.0784	$1,245.17	.	$249.04
21931	Exc back les sc 3+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
21932	Exc back tum deep < 5 cm		T	0021	18.0784	$1,245.17	.	$249.04
21933	Exc back tum deep 5+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
21935	Resect back tum < 5 cm		T	0021	18.0784	$1,245.17	.	$249.04
21936	Resect back tum 5+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
22010	I&d p-spine c/t/cerv-thor		C					
22015	I&d p-spine l/s/ls		C					
22100	Remove part of neck vertebra		T	0208	51.3375	$3,535.92	.	$707.19
22101	Remove part thorax vertebra		T	0208	51.3375	$3,535.92	.	$707.19
22102	Remove part lumbar vertebra		T	0208	51.3375	$3,535.92	.	$707.19
22103	Remove extra spine segment		T	0208	51.3375	$3,535.92	.	$707.19
22110	Remove part of neck vertebra		C					
22112	Remove part thorax vertebra		C					
22114	Remove part lumbar vertebra		C					
22116	Remove extra spine segment		C					
22206	Cut spine 3 col thor		C					
22207	Cut spine 3 col lumb		C					
22208	Cut spine 3 col addl seg		C					
22210	Revision of neck spine		C					
22212	Revision of thorax spine		C					
22214	Revision of lumbar spine		C					
22216	Revise extra spine segment		C					
22220	Revision of neck spine		C					
22222	Revision of thorax spine		T	0208	51.3375	$3,535.92	.	$707.19
22224	Revision of lumbar spine		C					
22226	Revise extra spine segment		C					
22305	Treat spine process fracture		T	0129	1.5787	$108.73	.	$21.75
22310	Treat spine fracture		T	0138	5.5050	$379.16	.	$75.84
22315	Treat spine fracture		T	0139	20.8356	$1,435.07	.	$287.02
22318	Treat odontoid fx w/o graft		C					
22319	Treat odontoid fx w/graft		C					

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22325	Treat spine fracture		C					
22326	Treat neck spine fracture		C					
22327	Treat thorax spine fracture		C					
22328	Treat each add spine fx		C					
22505	Manipulation of spine		T	0045	15.5512	$1,071.10	$268.44	$214.22
22520	Percut vertebroplasty thor		T	0050	32.2439	$2,220.83	.	$444.17
22521	Percut vertebroplasty lumb		T	0050	32.2439	$2,220.83	.	$444.17
22522	Percut vertebroplasty addl		T	0050	32.2439	$2,220.83	.	$444.17
22523	Percut kyphoplasty thor		T	0052	88.9869	$6,129.06	.	$1,225.82
22524	Percut kyphoplasty lumbar		T	0052	88.9869	$6,129.06	.	$1,225.82
22525	Percut kyphoplasty add-on		T	0052	88.9869	$6,129.06	.	$1,225.82
22526	Idet single level		E					
22527	Idet 1 or more levels		E					
22532	Lat thorax spine fusion		C					
22533	Lat lumbar spine fusion		C					
22534	Lat thor/lumb addl seg		C					
22548	Neck spine fusion		C					
22551	Neck spine fuse&remove addl	NI	C					
22552	Addl neck spine fusion	NI	C					
22554	Neck spine fusion		C					
22556	Thorax spine fusion		C					
22558	Lumbar spine fusion		C					
22585	Additional spinal fusion		C					
22590	Spine & skull spinal fusion		C					
22595	Neck spinal fusion		C					
22600	Neck spine fusion		C					
22610	Thorax spine fusion		C					
22612	Lumbar spine fusion		T	0208	51.3375	$3,535.92	.	$707.19
22614	Spine fusion extra segment		T	0208	51.3375	$3,535.92	.	$707.19
22630	Lumbar spine fusion		C					
22632	Spine fusion extra segment		C					
22800	Fusion of spine		C					
22802	Fusion of spine		C					
22804	Fusion of spine		C					
22808	Fusion of spine		C					
22810	Fusion of spine		C					
22812	Fusion of spine		C					
22818	Kyphectomy 1-2 segments		C					
22819	Kyphectomy 3 or more		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22830	Exploration of spinal fusion		C					
22840	Insert spine fixation device		C					
22841	Insert spine fixation device		C					
22842	Insert spine fixation device		C					
22843	Insert spine fixation device		C					
22844	Insert spine fixation device		C					
22845	Insert spine fixation device		C					
22846	Insert spine fixation device		C					
22847	Insert spine fixation device		C					
22848	Insert pelv fixation device		C					
22849	Reinsert spinal fixation		C					
22850	Remove spine fixation device		C					
22851	Apply spine prosth device		T	0049	22.9744	$1,582.38	.	$316.48
22852	Remove spine fixation device		C					
22855	Remove spine fixation device		C					
22856	Cerv artific diskectomy		C					
22857	Lumbar artif diskectomy		C					
22861	Revise cerv artific disc		C					
22862	Revise lumbar artif disc		C					
22864	Remove cerv artif disc		C					
22865	Remove lumb artif disc		C					
22899	Spine surgery procedure		T	0049	22.9744	$1,582.38	.	$316.48
22900	Exc back tum deep < 5 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
22901	Exc back tum deep 5+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
22902	Exc abd les sc < 3 cm		T	0021	18.0784	$1,245.17	.	$249.04
22903	Exc abd les sc > 3 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
22904	Resect abd tum < 5 cm		T	0021	18.0784	$1,245.17	.	$249.04
22905	Resect abd tum > 5 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
22999	Abdomen surgery procedure		T	0049	22.9744	$1,582.38	.	$316.48
23000	Removal of calcium deposits		T	0021	18.0784	$1,245.17	.	$249.04
23020	Release shoulder joint		T	0051	47.3213	$3,259.30	.	$651.86
23030	Drain shoulder lesion		T	0008	20.1996	$1,391.27	.	$278.26
23031	Drain shoulder bursa		T	0008	20.1996	$1,391.27	.	$278.26
23035	Drain shoulder bone lesion		T	0049	22.9744	$1,582.38	.	$316.48
23040	Exploratory shoulder surgery		T	0050	32.2439	$2,220.83	.	$444.17
23044	Exploratory shoulder surgery		T	0050	32.2439	$2,220.83	.	$444.17
23065	Biopsy shoulder tissues		T	0020	8.4929	$584.96	.	$117.00
23066	Biopsy shoulder tissues		T	0022	23.8986	$1,646.04	$354.45	$329.21
23071	Exc shoulder les sc > 3 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21

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23073	Exc shoulder tum deep > 5 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
23075	Exc shoulder les sc < 3 cm		T	0021	18.0784	$1,245.17	.	$249.04
23076	Exc shoulder tum deep < 5 cm		T	0021	18.0784	$1,245.17	.	$249.04
23077	Resect shoulder tum < 5 cm		T	0021	18.0784	$1,245.17	.	$249.04
23078	Resect shoulder tum > 5 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
23100	Biopsy of shoulder joint		T	0049	22.9744	$1,582.38	.	$316.48
23101	Shoulder joint surgery		T	0050	32.2439	$2,220.83	.	$444.17
23105	Remove shoulder joint lining		T	0050	32.2439	$2,220.83	.	$444.17
23106	Incision of collarbone joint		T	0050	32.2439	$2,220.83	.	$444.17
23107	Explore treat shoulder joint		T	0050	32.2439	$2,220.83	.	$444.17
23120	Partial removal collar bone		T	0050	32.2439	$2,220.83	.	$444.17
23125	Removal of collar bone		T	0050	32.2439	$2,220.83	.	$444.17
23130	Remove shoulder bone part		T	0051	47.3213	$3,259.30	.	$651.86
23140	Removal of bone lesion		T	0049	22.9744	$1,582.38	.	$316.48
23145	Removal of bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
23146	Removal of bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
23150	Removal of humerus lesion		T	0050	32.2439	$2,220.83	.	$444.17
23155	Removal of humerus lesion		T	0050	32.2439	$2,220.83	.	$444.17
23156	Removal of humerus lesion		T	0050	32.2439	$2,220.83	.	$444.17
23170	Remove collar bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
23172	Remove shoulder blade lesion		T	0050	32.2439	$2,220.83	.	$444.17
23174	Remove humerus lesion		T	0050	32.2439	$2,220.83	.	$444.17
23180	Remove collar bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
23182	Remove shoulder blade lesion		T	0050	32.2439	$2,220.83	.	$444.17
23184	Remove humerus lesion		T	0050	32.2439	$2,220.83	.	$444.17
23190	Partial removal of scapula		T	0050	32.2439	$2,220.83	.	$444.17
23195	Removal of head of humerus		T	0050	32.2439	$2,220.83	.	$444.17
23200	Resect clavicle tumor		C					
23210	Resect scapula tumor		C					
23220	Resect prox humerus tumor		C					
23330	Remove shoulder foreign body		T	0020	8.4929	$584.96	.	$117.00
23331	Remove shoulder foreign body		T	0022	23.8986	$1,646.04	$354.45	$329.21
23332	Remove shoulder foreign body		C					
23350	Injection for shoulder x-ray		N					
23395	Muscle transfer shoulder/arm		T	0051	47.3213	$3,259.30	.	$651.86
23397	Muscle transfers		T	0052	88.9869	$6,129.06	.	$1,225.82
23400	Fixation of shoulder blade		T	0050	32.2439	$2,220.83	.	$444.17
23405	Incision of tendon & muscle		T	0050	32.2439	$2,220.83	.	$444.17
23406	Incise tendon(s) & muscle(s)		T	0050	32.2439	$2,220.83	.	$444.17

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23410	Repair rotator cuff acute		T	0051	47.3213	$3,259.30	.	$651.86
23412	Repair rotator cuff chronic		T	0051	47.3213	$3,259.30	.	$651.86
23415	Release of shoulder ligament		T	0051	47.3213	$3,259.30	.	$651.86
23420	Repair of shoulder		T	0051	47.3213	$3,259.30	.	$651.86
23430	Repair biceps tendon		T	0051	47.3213	$3,259.30	.	$651.86
23440	Remove/transplant tendon		T	0051	47.3213	$3,259.30	.	$651.86
23450	Repair shoulder capsule		T	0052	88.9869	$6,129.06	.	$1,225.82
23455	Repair shoulder capsule		T	0052	88.9869	$6,129.06	.	$1,225.82
23460	Repair shoulder capsule		T	0052	88.9869	$6,129.06	.	$1,225.82
23462	Repair shoulder capsule		T	0051	47.3213	$3,259.30	.	$651.86
23465	Repair shoulder capsule		T	0052	88.9869	$6,129.06	.	$1,225.82
23466	Repair shoulder capsule		T	0051	47.3213	$3,259.30	.	$651.86
23470	Reconstruct shoulder joint		T	0425	124.8075	$8,596.24	.	$1,719.25
23472	Reconstruct shoulder joint		C					
23480	Revision of collar bone		T	0051	47.3213	$3,259.30	.	$651.86
23485	Revision of collar bone		T	0052	88.9869	$6,129.06	.	$1,225.82
23490	Reinforce clavicle	CH	T	0052	88.9869	$6,129.06	.	$1,225.82
23491	Reinforce shoulder bones		T	0052	88.9869	$6,129.06	.	$1,225.82
23500	Treat clavicle fracture		T	0129	1.5787	$108.73	.	$21.75
23505	Treat clavicle fracture		T	0139	20.8356	$1,435.07	.	$287.02
23515	Treat clavicle fracture		T	0064	66.9057	$4,608.20	.	$921.64
23520	Treat clavicle dislocation		T	0138	5.5050	$379.16	.	$75.84
23525	Treat clavicle dislocation		T	0138	5.5050	$379.16	.	$75.84
23530	Treat clavicle dislocation		T	0063	48.1318	$3,315.13	.	$663.03
23532	Treat clavicle dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
23540	Treat clavicle dislocation		T	0129	1.5787	$108.73	.	$21.75
23545	Treat clavicle dislocation		T	0138	5.5050	$379.16	.	$75.84
23550	Treat clavicle dislocation		T	0063	48.1318	$3,315.13	.	$663.03
23552	Treat clavicle dislocation		T	0063	48.1318	$3,315.13	.	$663.03
23570	Treat shoulder blade fx		T	0129	1.5787	$108.73	.	$21.75
23575	Treat shoulder blade fx		T	0138	5.5050	$379.16	.	$75.84
23585	Treat scapula fracture		T	0064	66.9057	$4,608.20	.	$921.64
23600	Treat humerus fracture		T	0129	1.5787	$108.73	.	$21.75
23605	Treat humerus fracture		T	0139	20.8356	$1,435.07	.	$287.02
23615	Treat humerus fracture		T	0064	66.9057	$4,608.20	.	$921.64
23616	Treat humerus fracture		T	0064	66.9057	$4,608.20	.	$921.64
23620	Treat humerus fracture		T	0129	1.5787	$108.73	.	$21.75
23625	Treat humerus fracture		T	0139	20.8356	$1,435.07	.	$287.02
23630	Treat humerus fracture		T	0064	66.9057	$4,608.20	.	$921.64

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23650	Treat shoulder dislocation		T	0129	1.5787	$108.73	.	$21.75
23655	Treat shoulder dislocation		T	0045	15.5512	$1,071.10	$268.44	$214.22
23660	Treat shoulder dislocation		T	0063	48.1318	$3,315.13	.	$663.03
23665	Treat dislocation/fracture		T	0138	5.5050	$379.16	.	$75.84
23670	Treat dislocation/fracture		T	0064	66.9057	$4,608.20	.	$921.64
23675	Treat dislocation/fracture		T	0129	1.5787	$108.73	.	$21.75
23680	Treat dislocation/fracture		T	0063	48.1318	$3,315.13	.	$663.03
23700	Fixation of shoulder		T	0045	15.5512	$1,071.10	$268.44	$214.22
23800	Fusion of shoulder joint		T	0052	88.9869	$6,129.06	.	$1,225.82
23802	Fusion of shoulder joint	CH	T	0052	88.9869	$6,129.06	.	$1,225.82
23900	Amputation of arm & girdle		C					
23920	Amputation at shoulder joint		C					
23921	Amputation follow-up surgery		T	0136	17.2117	$1,185.47	.	$237.10
23929	Shoulder surgery procedure		T	0129	1.5787	$108.73	.	$21.75
23930	Drainage of arm lesion		T	0008	20.1996	$1,391.27	.	$278.26
23931	Drainage of arm bursa		T	0008	20.1996	$1,391.27	.	$278.26
23935	Drain arm/elbow bone lesion		T	0049	22.9744	$1,582.38	.	$316.48
24000	Exploratory elbow surgery		T	0050	32.2439	$2,220.83	.	$444.17
24006	Release elbow joint		T	0050	32.2439	$2,220.83	.	$444.17
24065	Biopsy arm/elbow soft tissue		T	0021	18.0784	$1,245.17	.	$249.04
24066	Biopsy arm/elbow soft tissue		T	0021	18.0784	$1,245.17	.	$249.04
24071	Exc arm/elbow les sc 3+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
24073	Ex arm/elbow tum deep > 5 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
24075	Exc arm/elbow les sc < 3 cm		T	0021	18.0784	$1,245.17	.	$249.04
24076	Ex arm/elbow tum deep < 5 cm		T	0021	18.0784	$1,245.17	.	$249.04
24077	Resect arm/elbow tum < 5 cm		T	0021	18.0784	$1,245.17	.	$249.04
24079	Resect arm/elbow tum > 5 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
24100	Biopsy elbow joint lining		T	0049	22.9744	$1,582.38	.	$316.48
24101	Explore/treat elbow joint		T	0050	32.2439	$2,220.83	.	$444.17
24102	Remove elbow joint lining		T	0050	32.2439	$2,220.83	.	$444.17
24105	Removal of elbow bursa		T	0049	22.9744	$1,582.38	.	$316.48
24110	Remove humerus lesion		T	0049	22.9744	$1,582.38	.	$316.48
24115	Remove/graft bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
24116	Remove/graft bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
24120	Remove elbow lesion		T	0049	22.9744	$1,582.38	.	$316.48
24125	Remove/graft bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
24126	Remove/graft bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
24130	Removal of head of radius		T	0050	32.2439	$2,220.83	.	$444.17
24134	Removal of arm bone lesion		T	0050	32.2439	$2,220.83	.	$444.17

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24136	Remove radius bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
24138	Remove elbow bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
24140	Partial removal of arm bone		T	0050	32.2439	$2,220.83	.	$444.17
24145	Partial removal of radius		T	0050	32.2439	$2,220.83	.	$444.17
24147	Partial removal of elbow		T	0050	32.2439	$2,220.83	.	$444.17
24149	Radical resection of elbow		T	0050	32.2439	$2,220.83	.	$444.17
24150	Resect distal humerus tumor		T	0051	47.3213	$3,259.30	.	$651.86
24152	Resect radius tumor		T	0051	47.3213	$3,259.30	.	$651.86
24155	Removal of elbow joint		T	0051	47.3213	$3,259.30	.	$651.86
24160	Remove elbow joint implant		T	0050	32.2439	$2,220.83	.	$444.17
24164	Remove radius head implant		T	0050	32.2439	$2,220.83	.	$444.17
24200	Removal of arm foreign body		T	0019	5.0887	$350.49	.	$70.10
24201	Removal of arm foreign body		T	0021	18.0784	$1,245.17	.	$249.04
24220	Injection for elbow x-ray		N					
24300	Manipulate elbow w/anesth		T	0045	15.5512	$1,071.10	$268.44	$214.22
24301	Muscle/tendon transfer		T	0050	32.2439	$2,220.83	.	$444.17
24305	Arm tendon lengthening		T	0050	32.2439	$2,220.83	.	$444.17
24310	Revision of arm tendon		T	0049	22.9744	$1,582.38	.	$316.48
24320	Repair of arm tendon		T	0051	47.3213	$3,259.30	.	$651.86
24330	Revision of arm muscles		T	0052	88.9869	$6,129.06	.	$1,225.82
24331	Revision of arm muscles		T	0051	47.3213	$3,259.30	.	$651.86
24332	Tenolysis triceps		T	0049	22.9744	$1,582.38	.	$316.48
24340	Repair of biceps tendon		T	0051	47.3213	$3,259.30	.	$651.86
24341	Repair arm tendon/muscle		T	0051	47.3213	$3,259.30	.	$651.86
24342	Repair of ruptured tendon		T	0051	47.3213	$3,259.30	.	$651.86
24343	Repr elbow lat ligmnt w/tiss		T	0050	32.2439	$2,220.83	.	$444.17
24344	Reconstruct elbow lat ligmnt		T	0052	88.9869	$6,129.06	.	$1,225.82
24345	Repr elbw med ligmnt w/tissu		T	0050	32.2439	$2,220.83	.	$444.17
24346	Reconstruct elbow med ligmnt	CH	T	0052	88.9869	$6,129.06	.	$1,225.82
24357	Repair elbow perc		T	0050	32.2439	$2,220.83	.	$444.17
24358	Repair elbow w/deb open		T	0050	32.2439	$2,220.83	.	$444.17
24359	Repair elbow deb/attch open		T	0050	32.2439	$2,220.83	.	$444.17
24360	Reconstruct elbow joint		T	0047	39.2855	$2,705.83	.	$541.17
24361	Reconstruct elbow joint		T	0425	124.8075	$8,596.24	.	$1,719.25
24362	Reconstruct elbow joint		T	0048	59.9568	$4,129.58	.	$825.92
24363	Replace elbow joint		T	0425	124.8075	$8,596.24	.	$1,719.25
24365	Reconstruct head of radius		T	0047	39.2855	$2,705.83	.	$541.17
24366	Reconstruct head of radius		T	0425	124.8075	$8,596.24	.	$1,719.25
24400	Revision of humerus	CH	T	0052	88.9869	$6,129.06	.	$1,225.82

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24410	Revision of humerus		T	0051	47.3213	$3,259.30	.	$651.86
24420	Revision of humerus		T	0051	47.3213	$3,259.30	.	$651.86
24430	Repair of humerus		T	0052	88.9869	$6,129.06	.	$1,225.82
24435	Repair humerus with graft		T	0052	88.9869	$6,129.06	.	$1,225.82
24470	Revision of elbow joint		T	0051	47.3213	$3,259.30	.	$651.86
24495	Decompression of forearm		T	0050	32.2439	$2,220.83	.	$444.17
24498	Reinforce humerus		T	0052	88.9869	$6,129.06	.	$1,225.82
24500	Treat humerus fracture		T	0129	1.5787	$108.73	.	$21.75
24505	Treat humerus fracture		T	0129	1.5787	$108.73	.	$21.75
24515	Treat humerus fracture		T	0064	66.9057	$4,608.20	.	$921.64
24516	Treat humerus fracture		T	0064	66.9057	$4,608.20	.	$921.64
24530	Treat humerus fracture		T	0129	1.5787	$108.73	.	$21.75
24535	Treat humerus fracture		T	0138	5.5050	$379.16	.	$75.84
24538	Treat humerus fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
24545	Treat humerus fracture		T	0064	66.9057	$4,608.20	.	$921.64
24546	Treat humerus fracture		T	0064	66.9057	$4,608.20	.	$921.64
24560	Treat humerus fracture		T	0129	1.5787	$108.73	.	$21.75
24565	Treat humerus fracture		T	0129	1.5787	$108.73	.	$21.75
24566	Treat humerus fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
24575	Treat humerus fracture		T	0064	66.9057	$4,608.20	.	$921.64
24576	Treat humerus fracture		T	0129	1.5787	$108.73	.	$21.75
24577	Treat humerus fracture	CH	T	0129	1.5787	$108.73	.	$21.75
24579	Treat humerus fracture		T	0064	66.9057	$4,608.20	.	$921.64
24582	Treat humerus fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
24586	Treat elbow fracture		T	0064	66.9057	$4,608.20	.	$921.64
24587	Treat elbow fracture		T	0064	66.9057	$4,608.20	.	$921.64
24600	Treat elbow dislocation		T	0129	1.5787	$108.73	.	$21.75
24605	Treat elbow dislocation		T	0045	15.5512	$1,071.10	$268.44	$214.22
24615	Treat elbow dislocation		T	0064	66.9057	$4,608.20	.	$921.64
24620	Treat elbow fracture		T	0139	20.8356	$1,435.07	.	$287.02
24635	Treat elbow fracture		T	0064	66.9057	$4,608.20	.	$921.64
24640	Treat elbow dislocation		T	0129	1.5787	$108.73	.	$21.75
24650	Treat radius fracture		T	0129	1.5787	$108.73	.	$21.75
24655	Treat radius fracture		T	0138	5.5050	$379.16	.	$75.84
24665	Treat radius fracture		T	0063	48.1318	$3,315.13	.	$663.03
24666	Treat radius fracture		T	0064	66.9057	$4,608.20	.	$921.64
24670	Treat ulnar fracture		T	0129	1.5787	$108.73	.	$21.75
24675	Treat ulnar fracture		T	0129	1.5787	$108.73	.	$21.75
24685	Treat ulnar fracture		T	0063	48.1318	$3,315.13	.	$663.03

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24800	Fusion of elbow joint		T	0051	47.3213	$3,259.30	.	$651.86
24802	Fusion/graft of elbow joint	CH	T	0052	88.9869	$6,129.06	.	$1,225.82
24900	Amputation of upper arm		C					
24920	Amputation of upper arm		C					
24925	Amputation follow-up surgery		T	0049	22.9744	$1,582.38	.	$316.48
24930	Amputation follow-up surgery		C					
24931	Amputate upper arm & implant		C					
24935	Revision of amputation		T	0052	88.9869	$6,129.06	.	$1,225.82
24940	Revision of upper arm		C					
24999	Upper arm/elbow surgery		T	0129	1.5787	$108.73	.	$21.75
25000	Incision of tendon sheath		T	0049	22.9744	$1,582.38	.	$316.48
25001	Incise flexor carpi radialis		T	0049	22.9744	$1,582.38	.	$316.48
25020	Decompress forearm 1 space		T	0050	32.2439	$2,220.83	.	$444.17
25023	Decompress forearm 1 space		T	0050	32.2439	$2,220.83	.	$444.17
25024	Decompress forearm 2 spaces		T	0050	32.2439	$2,220.83	.	$444.17
25025	Decompress forearm 2 spaces		T	0050	32.2439	$2,220.83	.	$444.17
25028	Drainage of forearm lesion		T	0049	22.9744	$1,582.38	.	$316.48
25031	Drainage of forearm bursa		T	0049	22.9744	$1,582.38	.	$316.48
25035	Treat forearm bone lesion		T	0049	22.9744	$1,582.38	.	$316.48
25040	Explore/treat wrist joint		T	0050	32.2439	$2,220.83	.	$444.17
25065	Biopsy forearm soft tissues		T	0020	8.4929	$584.96		$117.00
25066	Biopsy forearm soft tissues		T	0022	23.8986	$1,646.04	$354.45	$329.21
25071	Exc forearm les sc > 3 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
25073	Exc forearm tum deep 3+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
25075	Exc forearm les sc < 3 cm		T	0021	18.0784	$1,245.17	.	$249.04
25076	Exc forearm tum deep < 3 cm		T	0021	18.0784	$1,245.17	.	$249.04
25077	Resect forearm/wrist tum<3cm		T	0021	18.0784	$1,245.17	.	$249.04
25078	Resect forearm/wrist tum3+cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
25085	Incision of wrist capsule		T	0049	22.9744	$1,582.38	.	$316.48
25100	Biopsy of wrist joint		T	0049	22.9744	$1,582.38	.	$316.48
25101	Explore/treat wrist joint		T	0050	32.2439	$2,220.83	.	$444.17
25105	Remove wrist joint lining		T	0050	32.2439	$2,220.83	.	$444.17
25107	Remove wrist joint cartilage		T	0050	32.2439	$2,220.83	.	$444.17
25109	Excise tendon forearm/wrist		T	0049	22.9744	$1,582.38	.	$316.48
25110	Remove wrist tendon lesion		T	0049	22.9744	$1,582.38	.	$316.48
25111	Remove wrist tendon lesion		T	0049	22.9744	$1,582.38	.	$316.48
25112	Reremove wrist tendon lesion		T	0049	22.9744	$1,582.38	.	$316.48
25115	Remove wrist/forearm lesion		T	0049	22.9744	$1,582.38	.	$316.48
25116	Remove wrist/forearm lesion		T	0049	22.9744	$1,582.38	.	$316.48

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25118	Excise wrist tendon sheath		T	0050	32.2439	$2,220.83	.	$444.17
25119	Partial removal of ulna		T	0050	32.2439	$2,220.83	.	$444.17
25120	Removal of forearm lesion		T	0050	32.2439	$2,220.83	.	$444.17
25125	Remove/graft forearm lesion		T	0050	32.2439	$2,220.83	.	$444.17
25126	Remove/graft forearm lesion		T	0050	32.2439	$2,220.83	.	$444.17
25130	Removal of wrist lesion		T	0050	32.2439	$2,220.83	.	$444.17
25135	Remove & graft wrist lesion		T	0050	32.2439	$2,220.83	.	$444.17
25136	Remove & graft wrist lesion		T	0050	32.2439	$2,220.83	.	$444.17
25145	Remove forearm bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
25150	Partial removal of ulna		T	0050	32.2439	$2,220.83	.	$444.17
25151	Partial removal of radius		T	0050	32.2439	$2,220.83	.	$444.17
25170	Resect radius/ulnar tumor		T	0051	47.3213	$3,259.30	.	$651.86
25210	Removal of wrist bone		T	0050	32.2439	$2,220.83	.	$444.17
25215	Removal of wrist bones		T	0050	32.2439	$2,220.83	.	$444.17
25230	Partial removal of radius		T	0050	32.2439	$2,220.83	.	$444.17
25240	Partial removal of ulna		T	0050	32.2439	$2,220.83	.	$444.17
25246	Injection for wrist x-ray		N					
25248	Remove forearm foreign body		T	0049	22.9744	$1,582.38	.	$316.48
25250	Removal of wrist prosthesis		T	0050	32.2439	$2,220.83	.	$444.17
25251	Removal of wrist prosthesis		T	0050	32.2439	$2,220.83	.	$444.17
25259	Manipulate wrist w/anesthes		T	0139	20.8356	$1,435.07	.	$287.02
25260	Repair forearm tendon/muscle		T	0050	32.2439	$2,220.83	.	$444.17
25263	Repair forearm tendon/muscle		T	0050	32.2439	$2,220.83	.	$444.17
25265	Repair forearm tendon/muscle		T	0050	32.2439	$2,220.83	.	$444.17
25270	Repair forearm tendon/muscle		T	0050	32.2439	$2,220.83	.	$444.17
25272	Repair forearm tendon/muscle		T	0050	32.2439	$2,220.83	.	$444.17
25274	Repair forearm tendon/muscle		T	0050	32.2439	$2,220.83	.	$444.17
25275	Repair forearm tendon sheath		T	0050	32.2439	$2,220.83	.	$444.17
25280	Revise wrist/forearm tendon		T	0050	32.2439	$2,220.83	.	$444.17
25290	Incise wrist/forearm tendon		T	0050	32.2439	$2,220.83	.	$444.17
25295	Release wrist/forearm tendon		T	0049	22.9744	$1,582.38	.	$316.48
25300	Fusion of tendons at wrist		T	0050	32.2439	$2,220.83	.	$444.17
25301	Fusion of tendons at wrist		T	0050	32.2439	$2,220.83	.	$444.17
25310	Transplant forearm tendon		T	0051	47.3213	$3,259.30	.	$651.86
25312	Transplant forearm tendon		T	0051	47.3213	$3,259.30	.	$651.86
25315	Revise palsy hand tendon(s)		T	0051	47.3213	$3,259.30	.	$651.86
25316	Revise palsy hand tendon(s)		T	0052	88.9869	$6,129.06	.	$1,225.82
25320	Repair/revise wrist joint		T	0051	47.3213	$3,259.30	.	$651.86
25332	Revise wrist joint		T	0047	39.2855	$2,705.83	.	$541.17

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25335	Realignment of hand		T	0051	47.3213	$3,259.30	.	$651.86
25337	Reconstruct ulna/radioulnar		T	0051	47.3213	$3,259.30	.	$651.86
25350	Revision of radius		T	0051	47.3213	$3,259.30	.	$651.86
25355	Revision of radius		T	0051	47.3213	$3,259.30	.	$651.86
25360	Revision of ulna		T	0051	47.3213	$3,259.30	.	$651.86
25365	Revise radius & ulna	CH	T	0052	88.9869	$6,129.06	.	$1,225.82
25370	Revise radius or ulna		T	0051	47.3213	$3,259.30	.	$651.86
25375	Revise radius & ulna		T	0051	47.3213	$3,259.30	.	$651.86
25390	Shorten radius or ulna		T	0051	47.3213	$3,259.30	.	$651.86
25391	Lengthen radius or ulna	CH	T	0052	88.9869	$6,129.06	.	$1,225.82
25392	Shorten radius & ulna		T	0050	32.2439	$2,220.83	.	$444.17
25393	Lengthen radius & ulna		T	0051	47.3213	$3,259.30	.	$651.86
25394	Repair carpal bone shorten		T	0051	47.3213	$3,259.30	.	$651.86
25400	Repair radius or ulna	CH	T	0052	88.9869	$6,129.06	.	$1,225.82
25405	Repair/graft radius or ulna		T	0052	88.9869	$6,129.06	.	$1,225.82
25415	Repair radius & ulna		T	0052	88.9869	$6,129.06	.	$1,225.82
25420	Repair/graft radius & ulna		T	0052	88.9869	$6,129.06	.	$1,225.82
25425	Repair/graft radius or ulna	CH	T	0052	88.9869	$6,129.06	.	$1,225.82
25426	Repair/graft radius & ulna		T	0051	47.3213	$3,259.30	.	$651.86
25430	Vasc graft into carpal bone		T	0051	47.3213	$3,259.30	.	$651.86
25431	Repair nonunion carpal bone		T	0051	47.3213	$3,259.30	.	$651.86
25440	Repair/graft wrist bone		T	0052	88.9869	$6,129.06	.	$1,225.82
25441	Reconstruct wrist joint		T	0425	124.8075	$8,596.24	.	$1,719.25
25442	Reconstruct wrist joint		T	0425	124.8075	$8,596.24	.	$1,719.25
25443	Reconstruct wrist joint		T	0048	59.9568	$4,129.58	.	$825.92
25444	Reconstruct wrist joint		T	0048	59.9568	$4,129.58	.	$825.92
25445	Reconstruct wrist joint		T	0048	59.9568	$4,129.58	.	$825.92
25446	Wrist replacement		T	0425	124.8075	$8,596.24	.	$1,719.25
25447	Repair wrist joint(s)		T	0047	39.2855	$2,705.83	.	$541.17
25449	Remove wrist joint implant		T	0047	39.2855	$2,705.83	.	$541.17
25450	Revision of wrist joint		T	0051	47.3213	$3,259.30	.	$651.86
25455	Revision of wrist joint		T	0051	47.3213	$3,259.30	.	$651.86
25490	Reinforce radius		T	0051	47.3213	$3,259.30	.	$651.86
25491	Reinforce ulna		T	0051	47.3213	$3,259.30	.	$651.86
25492	Reinforce radius and ulna		T	0051	47.3213	$3,259.30	.	$651.86
25500	Treat fracture of radius		T	0129	1.5787	$108.73	.	$21.75
25505	Treat fracture of radius		T	0138	5.5050	$379.16	.	$75.84
25515	Treat fracture of radius		T	0063	48.1318	$3,315.13	.	$663.03
25520	Treat fracture of radius		T	0138	5.5050	$379.16	.	$75.84

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25525	Treat fracture of radius		T	0063	48.1318	$3,315.13	.	$663.03
25526	Treat fracture of radius		T	0063	48.1318	$3,315.13	.	$663.03
25530	Treat fracture of ulna		T	0129	1.5787	$108.73	.	$21.75
25535	Treat fracture of ulna		T	0129	1.5787	$108.73	.	$21.75
25545	Treat fracture of ulna		T	0063	48.1318	$3,315.13	.	$663.03
25560	Treat fracture radius & ulna		T	0129	1.5787	$108.73	.	$21.75
25565	Treat fracture radius & ulna		T	0138	5.5050	$379.16	.	$75.84
25574	Treat fracture radius & ulna		T	0064	66.9057	$4,608.20	.	$921.64
25575	Treat fracture radius/ulna		T	0064	66.9057	$4,608.20	.	$921.64
25600	Treat fracture radius/ulna		T	0129	1.5787	$108.73	.	$21.75
25605	Treat fracture radius/ulna		T	0138	5.5050	$379.16	.	$75.84
25606	Treat fx distal radial		T	0062	26.5543	$1,828.95	$372.87	$365.79
25607	Treat fx rad extra-articul		T	0064	66.9057	$4,608.20	.	$921.64
25608	Treat fx rad intra-articul		T	0064	66.9057	$4,608.20	.	$921.64
25609	Treat fx radial 3+ frag		T	0064	66.9057	$4,608.20	.	$921.64
25622	Treat wrist bone fracture		T	0129	1.5787	$108.73	.	$21.75
25624	Treat wrist bone fracture		T	0138	5.5050	$379.16	.	$75.84
25628	Treat wrist bone fracture		T	0063	48.1318	$3,315.13	.	$663.03
25630	Treat wrist bone fracture		T	0129	1.5787	$108.73	.	$21.75
25635	Treat wrist bone fracture	CH	T	0129	1.5787	$108.73	.	$21.75
25645	Treat wrist bone fracture		T	0063	48.1318	$3,315.13	.	$663.03
25650	Treat wrist bone fracture		T	0129	1.5787	$108.73	.	$21.75
25651	Pin ulnar styloid fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
25652	Treat fracture ulnar styloid		T	0063	48.1318	$3,315.13	.	$663.03
25660	Treat wrist dislocation		T	0129	1.5787	$108.73	.	$21.75
25670	Treat wrist dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
25671	Pin radioulnar dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
25675	Treat wrist dislocation		T	0129	1.5787	$108.73	.	$21.75
25676	Treat wrist dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
25680	Treat wrist fracture		T	0129	1.5787	$108.73	.	$21.75
25685	Treat wrist fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
25690	Treat wrist dislocation		T	0139	20.8356	$1,435.07	.	$287.02
25695	Treat wrist dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
25800	Fusion of wrist joint		T	0052	88.9869	$6,129.06	.	$1,225.82
25805	Fusion/graft of wrist joint	CH	T	0052	88.9869	$6,129.06	.	$1,225.82
25810	Fusion/graft of wrist joint		T	0052	88.9869	$6,129.06	.	$1,225.82
25820	Fusion of hand bones		T	0051	47.3213	$3,259.30	.	$651.86
25825	Fuse hand bones with graft		T	0052	88.9869	$6,129.06	.	$1,225.82
25830	Fusion radioulnar jnt/ulna		T	0052	88.9869	$6,129.06	.	$1,225.82

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25900	Amputation of forearm		C					
25905	Amputation of forearm		C					
25907	Amputation follow-up surgery		T	0049	22.9744	$1,582.38	.	$316.48
25909	Amputation follow-up surgery	CH	T	0049	22.9744	$1,582.38	.	$316.48
25915	Amputation of forearm		C					
25920	Amputate hand at wrist		C					
25922	Amputate hand at wrist		T	0049	22.9744	$1,582.38	.	$316.48
25924	Amputation follow-up surgery		C					
25927	Amputation of hand		C					
25929	Amputation follow-up surgery		T	0136	17.2117	$1,185.47	.	$237.10
25931	Amputation follow-up surgery		T	0049	22.9744	$1,582.38	.	$316.48
25999	Forearm or wrist surgery		T	0129	1.5787	$108.73	.	$21.75
26010	Drainage of finger abscess		T	0006	1.4906	$102.67	.	$20.54
26011	Drainage of finger abscess		T	0007	13.0129	$896.28	.	$179.26
26020	Drain hand tendon sheath		T	0053	17.1642	$1,182.20	$253.49	$236.44
26025	Drainage of palm bursa		T	0053	17.1642	$1,182.20	$253.49	$236.44
26030	Drainage of palm bursa(s)		T	0053	17.1642	$1,182.20	$253.49	$236.44
26034	Treat hand bone lesion		T	0053	17.1642	$1,182.20	$253.49	$236.44
26035	Decompress fingers/hand		T	0053	17.1642	$1,182.20	$253.49	$236.44
26037	Decompress fingers/hand		T	0053	17.1642	$1,182.20	$253.49	$236.44
26040	Release palm contracture	CH	T	0053	17.1642	$1,182.20	$253.49	$236.44
26045	Release palm contracture		T	0054	29.7686	$2,050.34	.	$410.07
26055	Incise finger tendon sheath		T	0053	17.1642	$1,182.20	$253.49	$236.44
26060	Incision of finger tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44
26070	Explore/treat hand joint		T	0053	17.1642	$1,182.20	$253.49	$236.44
26075	Explore/treat finger joint		T	0053	17.1642	$1,182.20	$253.49	$236.44
26080	Explore/treat finger joint		T	0053	17.1642	$1,182.20	$253.49	$236.44
26100	Biopsy hand joint lining		T	0053	17.1642	$1,182.20	$253.49	$236.44
26105	Biopsy finger joint lining		T	0053	17.1642	$1,182.20	$253.49	$236.44
26110	Biopsy finger joint lining		T	0053	17.1642	$1,182.20	$253.49	$236.44
26111	Exc hand les sc > 1.5 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
26113	Exc hand tum deep > 1.5 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
26115	Exc hand les sc < 1.5 cm		T	0021	18.0784	$1,245.17	.	$249.04
26116	Exc hand tum deep < 1.5 cm		T	0021	18.0784	$1,245.17	.	$249.04
26117	Exc hand tum ra < 3 cm		T	0021	18.0784	$1,245.17	.	$249.04
26118	Exc hand tum ra > 3 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
26121	Release palm contracture		T	0054	29.7686	$2,050.34	.	$410.07
26123	Release palm contracture		T	0054	29.7686	$2,050.34	.	$410.07
26125	Release palm contracture		T	0053	17.1642	$1,182.20	$253.49	$236.44

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26130	Remove wrist joint lining		T	0053	17.1642	$1,182.20	$253.49	$236.44
26135	Revise finger joint each		T	0054	29.7686	$2,050.34	.	$410.07
26140	Revise finger joint each		T	0053	17.1642	$1,182.20	$253.49	$236.44
26145	Tendon excision palm/finger		T	0053	17.1642	$1,182.20	$253.49	$236.44
26160	Remove tendon sheath lesion		T	0053	17.1642	$1,182.20	$253.49	$236.44
26170	Removal of palm tendon each		T	0053	17.1642	$1,182.20	$253.49	$236.44
26180	Removal of finger tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44
26185	Remove finger bone		T	0053	17.1642	$1,182.20	$253.49	$236.44
26200	Remove hand bone lesion		T	0053	17.1642	$1,182.20	$253.49	$236.44
26205	Remove/graft bone lesion		T	0054	29.7686	$2,050.34	.	$410.07
26210	Removal of finger lesion		T	0053	17.1642	$1,182.20	$253.49	$236.44
26215	Remove/graft finger lesion		T	0053	17.1642	$1,182.20	$253.49	$236.44
26230	Partial removal of hand bone		T	0053	17.1642	$1,182.20	$253.49	$236.44
26235	Partial removal finger bone		T	0053	17.1642	$1,182.20	$253.49	$236.44
26236	Partial removal finger bone		T	0053	17.1642	$1,182.20	$253.49	$236.44
26250	Extensive hand surgery		T	0053	17.1642	$1,182.20	$253.49	$236.44
26260	Resect prox finger tumor		T	0053	17.1642	$1,182.20	$253.49	$236.44
26262	Resect distal finger tumor		T	0053	17.1642	$1,182.20	$253.49	$236.44
26320	Removal of implant from hand		T	0021	18.0784	$1,245.17	.	$249.04
26340	Manipulate finger w/anesth		T	0138	5.5050	$379.16	.	$75.84
26350	Repair finger/hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26352	Repair/graft hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26356	Repair finger/hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26357	Repair finger/hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26358	Repair/graft hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26370	Repair finger/hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26372	Repair/graft hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26373	Repair finger/hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26390	Revise hand/finger tendon		T	0054	29.7686	$2,050.34	.	$410.07
26392	Repair/graft hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26410	Repair hand tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44
26412	Repair/graft hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26415	Excision hand/finger tendon		T	0054	29.7686	$2,050.34	.	$410.07
26416	Graft hand or finger tendon		T	0054	29.7686	$2,050.34	.	$410.07
26418	Repair finger tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44
26420	Repair/graft finger tendon		T	0054	29.7686	$2,050.34	.	$410.07
26426	Repair finger/hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26428	Repair/graft finger tendon		T	0054	29.7686	$2,050.34	.	$410.07
26432	Repair finger tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26433	Repair finger tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44
26434	Repair/graft finger tendon		T	0054	29.7686	$2,050.34	.	$410.07
26437	Realignment of tendons		T	0053	17.1642	$1,182.20	$253.49	$236.44
26440	Release palm/finger tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44
26442	Release palm & finger tendon		T	0054	29.7686	$2,050.34	.	$410.07
26445	Release hand/finger tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44
26449	Release forearm/hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26450	Incision of palm tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44
26455	Incision of finger tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44
26460	Incise hand/finger tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44
26471	Fusion of finger tendons		T	0053	17.1642	$1,182.20	$253.49	$236.44
26474	Fusion of finger tendons		T	0053	17.1642	$1,182.20	$253.49	$236.44
26476	Tendon lengthening		T	0053	17.1642	$1,182.20	$253.49	$236.44
26477	Tendon shortening		T	0053	17.1642	$1,182.20	$253.49	$236.44
26478	Lengthening of hand tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44
26479	Shortening of hand tendon		T	0053	17.1642	$1,182.20	$253.49	$236.44
26480	Transplant hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26483	Transplant/graft hand tendon		T	0054	29.7686	$2,050.34	.	$410.07
26485	Transplant palm tendon		T	0054	29.7686	$2,050.34	.	$410.07
26489	Transplant/graft palm tendon		T	0054	29.7686	$2,050.34	.	$410.07
26490	Revise thumb tendon		T	0054	29.7686	$2,050.34	.	$410.07
26492	Tendon transfer with graft		T	0054	29.7686	$2,050.34	.	$410.07
26494	Hand tendon/muscle transfer		T	0054	29.7686	$2,050.34	.	$410.07
26496	Revise thumb tendon		T	0054	29.7686	$2,050.34	.	$410.07
26497	Finger tendon transfer		T	0054	29.7686	$2,050.34	.	$410.07
26498	Finger tendon transfer		T	0054	29.7686	$2,050.34	.	$410.07
26499	Revision of finger		T	0054	29.7686	$2,050.34	.	$410.07
26500	Hand tendon reconstruction		T	0053	17.1642	$1,182.20	$253.49	$236.44
26502	Hand tendon reconstruction		T	0054	29.7686	$2,050.34	.	$410.07
26508	Release thumb contracture		T	0053	17.1642	$1,182.20	$253.49	$236.44
26510	Thumb tendon transfer		T	0054	29.7686	$2,050.34	.	$410.07
26516	Fusion of knuckle joint		T	0054	29.7686	$2,050.34	.	$410.07
26517	Fusion of knuckle joints		T	0054	29.7686	$2,050.34	.	$410.07
26518	Fusion of knuckle joints		T	0054	29.7686	$2,050.34	.	$410.07
26520	Release knuckle contracture		T	0053	17.1642	$1,182.20	$253.49	$236.44
26525	Release finger contracture		T	0053	17.1642	$1,182.20	$253.49	$236.44
26530	Revise knuckle joint		T	0047	39.2855	$2,705.83	.	$541.17
26531	Revise knuckle with implant		T	0048	59.9568	$4,129.58	.	$825.92
26535	Revise finger joint		T	0047	39.2855	$2,705.83	.	$541.17

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26536	Revise/implant finger joint		T	0048	59.9568	$4,129.58	.	$825.92
26540	Repair hand joint		T	0053	17.1642	$1,182.20	$253.49	$236.44
26541	Repair hand joint with graft		T	0054	29.7686	$2,050.34	.	$410.07
26542	Repair hand joint with graft		T	0053	17.1642	$1,182.20	$253.49	$236.44
26545	Reconstruct finger joint		T	0054	29.7686	$2,050.34	.	$410.07
26546	Repair nonunion hand		T	0054	29.7686	$2,050.34	.	$410.07
26548	Reconstruct finger joint		T	0054	29.7686	$2,050.34	.	$410.07
26550	Construct thumb replacement		T	0054	29.7686	$2,050.34	.	$410.07
26551	Great toe-hand transfer		C					
26553	Single transfer toe-hand		C					
26554	Double transfer toe-hand		C					
26555	Positional change of finger		T	0054	29.7686	$2,050.34	.	$410.07
26556	Toe joint transfer		C					
26560	Repair of web finger		T	0053	17.1642	$1,182.20	$253.49	$236.44
26561	Repair of web finger		T	0054	29.7686	$2,050.34	.	$410.07
26562	Repair of web finger		T	0054	29.7686	$2,050.34	.	$410.07
26565	Correct metacarpal flaw		T	0054	29.7686	$2,050.34	.	$410.07
26567	Correct finger deformity		T	0054	29.7686	$2,050.34	.	$410.07
26568	Lengthen metacarpal/finger		T	0054	29.7686	$2,050.34	.	$410.07
26580	Repair hand deformity		T	0053	17.1642	$1,182.20	$253.49	$236.44
26587	Reconstruct extra finger		T	0053	17.1642	$1,182.20	$253.49	$236.44
26590	Repair finger deformity		T	0053	17.1642	$1,182.20	$253.49	$236.44
26591	Repair muscles of hand		T	0054	29.7686	$2,050.34		$410.07
26593	Release muscles of hand		T	0053	17.1642	$1,182.20	$253.49	$236.44
26596	Excision constricting tissue		T	0053	17.1642	$1,182.20	$253.49	$236.44
26600	Treat metacarpal fracture		T	0129	1.5787	$108.73	.	$21.75
26605	Treat metacarpal fracture		T	0129	1.5787	$108.73	.	$21.75
26607	Treat metacarpal fracture		T	0139	20.8356	$1,435.07	.	$287.02
26608	Treat metacarpal fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
26615	Treat metacarpal fracture		T	0063	48.1318	$3,315.13	.	$663.03
26641	Treat thumb dislocation		T	0129	1.5787	$108.73	.	$21.75
26645	Treat thumb fracture		T	0138	5.5050	$379.16	.	$75.84
26650	Treat thumb fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
26665	Treat thumb fracture		T	0063	48.1318	$3,315.13	.	$663.03
26670	Treat hand dislocation		T	0129	1.5787	$108.73	.	$21.75
26675	Treat hand dislocation	CH	T	0129	1.5787	$108.73	.	$21.75
26676	Pin hand dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
26685	Treat hand dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
26686	Treat hand dislocation		T	0064	66.9057	$4,608.20	.	$921.64

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26700	Treat knuckle dislocation		T	0129	1.5787	$108.73	.	$21.75
26705	Treat knuckle dislocation		T	0129	1.5787	$108.73	.	$21.75
26706	Pin knuckle dislocation		T	0139	20.8356	$1,435.07	.	$287.02
26715	Treat knuckle dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
26720	Treat finger fracture each		T	0129	1.5787	$108.73	.	$21.75
26725	Treat finger fracture each		T	0129	1.5787	$108.73	.	$21.75
26727	Treat finger fracture each		T	0062	26.5543	$1,828.95	$372.87	$365.79
26735	Treat finger fracture each		T	0062	26.5543	$1,828.95	$372.87	$365.79
26740	Treat finger fracture each		T	0129	1.5787	$108.73	.	$21.75
26742	Treat finger fracture each		T	0129	1.5787	$108.73	.	$21.75
26746	Treat finger fracture each		T	0062	26.5543	$1,828.95	$372.87	$365.79
26750	Treat finger fracture each		T	0129	1.5787	$108.73	.	$21.75
26755	Treat finger fracture each		T	0129	1.5787	$108.73	.	$21.75
26756	Pin finger fracture each		T	0062	26.5543	$1,828.95	$372.87	$365.79
26765	Treat finger fracture each		T	0062	26.5543	$1,828.95	$372.87	$365.79
26770	Treat finger dislocation		T	0129	1.5787	$108.73	.	$21.75
26775	Treat finger dislocation		T	0045	15.5512	$1,071.10	$268.44	$214.22
26776	Pin finger dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
26785	Treat finger dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
26820	Thumb fusion with graft		T	0054	29.7686	$2,050.34	.	$410.07
26841	Fusion of thumb		T	0054	29.7686	$2,050.34	.	$410.07
26842	Thumb fusion with graft		T	0054	29.7686	$2,050.34	.	$410.07
26843	Fusion of hand joint		T	0054	29.7686	$2,050.34	.	$410.07
26844	Fusion/graft of hand joint		T	0054	29.7686	$2,050.34	.	$410.07
26850	Fusion of knuckle		T	0054	29.7686	$2,050.34	.	$410.07
26852	Fusion of knuckle with graft		T	0054	29.7686	$2,050.34	.	$410.07
26860	Fusion of finger joint		T	0054	29.7686	$2,050.34	.	$410.07
26861	Fusion of finger jnt add-on		T	0054	29.7686	$2,050.34	.	$410.07
26862	Fusion/graft of finger joint		T	0054	29.7686	$2,050.34	.	$410.07
26863	Fuse/graft added joint		T	0054	29.7686	$2,050.34	.	$410.07
26910	Amputate metacarpal bone		T	0054	29.7686	$2,050.34	.	$410.07
26951	Amputation of finger/thumb		T	0053	17.1642	$1,182.20	$253.49	$236.44
26952	Amputation of finger/thumb		T	0053	17.1642	$1,182.20	$253.49	$236.44
26989	Hand/finger surgery		T	0129	1.5787	$108.73	.	$21.75
26990	Drainage of pelvis lesion		T	0049	22.9744	$1,582.38	.	$316.48
26991	Drainage of pelvis bursa		T	0049	22.9744	$1,582.38	.	$316.48
26992	Drainage of bone lesion		C					
27000	Incision of hip tendon		T	0049	22.9744	$1,582.38	.	$316.48
27001	Incision of hip tendon		T	0050	32.2439	$2,220.83	.	$444.17

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27003	Incision of hip tendon		T	0050	32.2439	$2,220.83	.	$444.17
27005	Incision of hip tendon		C					
27006	Incision of hip tendons		T	0050	32.2439	$2,220.83	.	$444.17
27025	Incision of hip/thigh fascia		C					
27027	Buttock fasciotomy		T	0049	22.9744	$1,582.38	.	$316.48
27030	Drainage of hip joint		C					
27033	Exploration of hip joint		T	0051	47.3213	$3,259.30	.	$651.86
27035	Denervation of hip joint		T	0051	47.3213	$3,259.30	.	$651.86
27036	Excision of hip joint/muscle		C					
27040	Biopsy of soft tissues		T	0020	8.4929	$584.96	.	$117.00
27041	Biopsy of soft tissues		T	0020	8.4929	$584.96	.	$117.00
27043	Exc hip pelvis les sc > 3 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
27045	Exc hip/pelv tum deep > 5 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
27047	Exc hip/pelvis les sc < 3 cm		T	0021	18.0784	$1,245.17	.	$249.04
27048	Exc hip/pelv tum deep < 5 cm		T	0021	18.0784	$1,245.17	.	$249.04
27049	Resect hip/pelv tum < 5 cm		T	0021	18.0784	$1,245.17	.	$249.04
27050	Biopsy of sacroiliac joint		T	0049	22.9744	$1,582.38	.	$316.48
27052	Biopsy of hip joint		T	0049	22.9744	$1,582.38	.	$316.48
27054	Removal of hip joint lining		C					
27057	Buttock fasciotomy w/dbrdmt		T	0049	22.9744	$1,582.38	.	$316.48
27059	Resect hip/pelv tum > 5 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
27060	Removal of ischial bursa		T	0049	22.9744	$1,582.38	.	$316.48
27062	Remove femur lesion/bursa		T	0049	22.9744	$1,582.38	.	$316.48
27065	Remove hip bone les super		T	0049	22.9744	$1,582.38	.	$316.48
27066	Remove hip bone les deep		T	0050	32.2439	$2,220.83	.	$444.17
27067	Remove/graft hip bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
27070	Part remove hip bone super		C					
27071	Part removal hip bone deep		C					
27075	Resect hip tumor		C					
27076	Resect hip tum incl acetabul		C					
27077	Resect hip tum w/innom bone		C					
27078	Rsect hip tum incl femur		C					
27080	Removal of tail bone		T	0050	32.2439	$2,220.83	.	$444.17
27086	Remove hip foreign body		T	0020	8.4929	$584.96	.	$117.00
27087	Remove hip foreign body		T	0049	22.9744	$1,582.38	.	$316.48
27090	Removal of hip prosthesis		C					
27091	Removal of hip prosthesis		C					
27093	Injection for hip x-ray		N					
27095	Injection for hip x-ray		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27096	Inject sacroiliac joint		B					
27097	Revision of hip tendon		T	0050	32.2439	$2,220.83	.	$444.17
27098	Transfer tendon to pelvis		T	0050	32.2439	$2,220.83	.	$444.17
27100	Transfer of abdominal muscle		T	0051	47.3213	$3,259.30	.	$651.86
27105	Transfer of spinal muscle		T	0051	47.3213	$3,259.30	.	$651.86
27110	Transfer of iliopsoas muscle		T	0051	47.3213	$3,259.30	.	$651.86
27111	Transfer of iliopsoas muscle		T	0051	47.3213	$3,259.30	.	$651.86
27120	Reconstruction of hip socket		C					
27122	Reconstruction of hip socket		C					
27125	Partial hip replacement		C					
27130	Total hip arthroplasty		C					
27132	Total hip arthroplasty		C					
27134	Revise hip joint replacement		C					
27137	Revise hip joint replacement		C					
27138	Revise hip joint replacement		C					
27140	Transplant femur ridge		C					
27146	Incision of hip bone		C					
27147	Revision of hip bone		C					
27151	Incision of hip bones		C					
27156	Revision of hip bones		C					
27158	Revision of pelvis		C					
27161	Incision of neck of femur		C					
27165	Incision/fixation of femur		C					
27170	Repair/graft femur head/neck		C					
27175	Treat slipped epiphysis		C					
27176	Treat slipped epiphysis		C					
27177	Treat slipped epiphysis		C					
27178	Treat slipped epiphysis		C					
27179	Revise head/neck of femur		T	0052	88.9869	$6,129.06	.	$1,225.82
27181	Treat slipped epiphysis		C					
27185	Revision of femur epiphysis		C					
27187	Reinforce hip bones		C					
27193	Treat pelvic ring fracture		T	0129	1.5787	$108.73	.	$21.75
27194	Treat pelvic ring fracture		T	0045	15.5512	$1,071.10	$268.44	$214.22
27200	Treat tail bone fracture		T	0129	1.5787	$108.73	.	$21.75
27202	Treat tail bone fracture		T	0063	48.1318	$3,315.13	.	$663.03
27215	Treat pelvic fracture(s)		E					
27216	Treat pelvic ring fracture		E					
27217	Treat pelvic ring fracture		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27218	Treat pelvic ring fracture		E					
27220	Treat hip socket fracture		T	0129	1.5787	$108.73	.	$21.75
27222	Treat hip socket fracture		C					
27226	Treat hip wall fracture		C					
27227	Treat hip fracture(s)		C					
27228	Treat hip fracture(s)		C					
27230	Treat thigh fracture		T	0129	1.5787	$108.73	.	$21.75
27232	Treat thigh fracture		C					
27235	Treat thigh fracture		T	0050	32.2439	$2,220.83	.	$444.17
27236	Treat thigh fracture		C					
27238	Treat thigh fracture		T	0138	5.5050	$379.16	.	$75.84
27240	Treat thigh fracture		C					
27244	Treat thigh fracture		C					
27245	Treat thigh fracture		C					
27246	Treat thigh fracture		T	0138	5.5050	$379.16	.	$75.84
27248	Treat thigh fracture		C					
27250	Treat hip dislocation		T	0129	1.5787	$108.73	.	$21.75
27252	Treat hip dislocation		T	0045	15.5512	$1,071.10	$268.44	$214.22
27253	Treat hip dislocation		C					
27254	Treat hip dislocation		C					
27256	Treat hip dislocation		T	0129	1.5787	$108.73	.	$21.75
27257	Treat hip dislocation		T	0045	15.5512	$1,071.10	$268.44	$214.22
27258	Treat hip dislocation		C					
27259	Treat hip dislocation		C					
27265	Treat hip dislocation		T	0129	1.5787	$108.73	.	$21.75
27266	Treat hip dislocation		T	0045	15.5512	$1,071.10	$268.44	$214.22
27267	Cltx thigh fx		T	0129	1.5787	$108.73	.	$21.75
27268	Cltx thigh fx w/mnpj		C					
27269	Optx thigh fx		C					
27275	Manipulation of hip joint		T	0045	15.5512	$1,071.10	$268.44	$214.22
27280	Fusion of sacroiliac joint		C					
27282	Fusion of pubic bones		C					
27284	Fusion of hip joint		C					
27286	Fusion of hip joint		C					
27290	Amputation of leg at hip		C					
27295	Amputation of leg at hip		C					
27299	Pelvis/hip joint surgery		T	0129	1.5787	$108.73	.	$21.75
27301	Drain thigh/knee lesion		T	0008	20.1996	$1,391.27	.	$278.26
27303	Drainage of bone lesion		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27305	Incise thigh tendon & fascia		T	0049	22.9744	$1,582.38	.	$316.48
27306	Incision of thigh tendon		T	0049	22.9744	$1,582.38	.	$316.48
27307	Incision of thigh tendons		T	0049	22.9744	$1,582.38	.	$316.48
27310	Exploration of knee joint		T	0050	32.2439	$2,220.83	.	$444.17
27323	Biopsy thigh soft tissues		T	0020	8.4929	$584.96	.	$117.00
27324	Biopsy thigh soft tissues		T	0022	23.8986	$1,646.04	$354.45	$329.21
27325	Neurectomy hamstring		T	0220	19.1325	$1,317.77	.	$263.56
27326	Neurectomy popliteal		T	0220	19.1325	$1,317.77	.	$263.56
27327	Exc thigh/knee les sc < 3 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
27328	Exc thigh/knee tum deep <5cm		T	0021	18.0784	$1,245.17	.	$249.04
27329	Resect thigh/knee tum < 5 cm		T	0021	18.0784	$1,245.17	.	$249.04
27330	Biopsy knee joint lining		T	0050	32.2439	$2,220.83	.	$444.17
27331	Explore/treat knee joint		T	0050	32.2439	$2,220.83	.	$444.17
27332	Removal of knee cartilage		T	0050	32.2439	$2,220.83	.	$444.17
27333	Removal of knee cartilage		T	0050	32.2439	$2,220.83	.	$444.17
27334	Remove knee joint lining		T	0050	32.2439	$2,220.83	.	$444.17
27335	Remove knee joint lining		T	0050	32.2439	$2,220.83	.	$444.17
27337	Exc thigh/knee les sc 3+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
27339	Exc thigh/knee tum deep 5+cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
27340	Removal of kneecap bursa		T	0049	22.9744	$1,582.38	.	$316.48
27345	Removal of knee cyst		T	0049	22.9744	$1,582.38	.	$316.48
27347	Remove knee cyst		T	0049	22.9744	$1,582.38	.	$316.48
27350	Removal of kneecap		T	0050	32.2439	$2,220.83	.	$444.17
27355	Remove femur lesion		T	0050	32.2439	$2,220.83	.	$444.17
27356	Remove femur lesion/graft		T	0050	32.2439	$2,220.83	.	$444.17
27357	Remove femur lesion/graft		T	0050	32.2439	$2,220.83	.	$444.17
27358	Remove femur lesion/fixation		T	0050	32.2439	$2,220.83	.	$444.17
27360	Partial removal leg bone(s)		T	0050	32.2439	$2,220.83	.	$444.17
27364	Resect thigh/knee tum 5+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
27365	Resect femur/knee tumor		C					
27370	Injection for knee x-ray		N					
27372	Removal of foreign body		T	0022	23.8986	$1,646.04	$354.45	$329.21
27380	Repair of kneecap tendon		T	0049	22.9744	$1,582.38	.	$316.48
27381	Repair/graft kneecap tendon		T	0049	22.9744	$1,582.38	.	$316.48
27385	Repair of thigh muscle		T	0049	22.9744	$1,582.38	.	$316.48
27386	Repair/graft of thigh muscle		T	0049	22.9744	$1,582.38	.	$316.48
27390	Incision of thigh tendon		T	0049	22.9744	$1,582.38	.	$316.48
27391	Incision of thigh tendons		T	0049	22.9744	$1,582.38	.	$316.48
27392	Incision of thigh tendons		T	0049	22.9744	$1,582.38	.	$316.48

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27393	Lengthening of thigh tendon		T	0050	32.2439	$2,220.83	.	$444.17
27394	Lengthening of thigh tendons		T	0050	32.2439	$2,220.83	.	$444.17
27395	Lengthening of thigh tendons		T	0051	47.3213	$3,259.30	.	$651.86
27396	Transplant of thigh tendon		T	0050	32.2439	$2,220.83	.	$444.17
27397	Transplants of thigh tendons		T	0051	47.3213	$3,259.30	.	$651.86
27400	Revise thigh muscles/tendons		T	0051	47.3213	$3,259.30	.	$651.86
27403	Repair of knee cartilage		T	0050	32.2439	$2,220.83	.	$444.17
27405	Repair of knee ligament		T	0051	47.3213	$3,259.30	.	$651.86
27407	Repair of knee ligament		T	0052	88.9869	$6,129.06	.	$1,225.82
27409	Repair of knee ligaments	CH	T	0052	88.9869	$6,129.06	.	$1,225.82
27412	Autochondrocyte implant knee		T	0052	88.9869	$6,129.06	.	$1,225.82
27415	Osteochondral knee allograft		T	0052	88.9869	$6,129.06	.	$1,225.82
27416	Osteochondral knee autograft		T	0051	47.3213	$3,259.30	.	$651.86
27418	Repair degenerated kneecap		T	0051	47.3213	$3,259.30	.	$651.86
27420	Revision of unstable kneecap		T	0051	47.3213	$3,259.30	.	$651.86
27422	Revision of unstable kneecap		T	0051	47.3213	$3,259.30	.	$651.86
27424	Revision/removal of kneecap		T	0051	47.3213	$3,259.30	.	$651.86
27425	Lat retinacular release open		T	0050	32.2439	$2,220.83	.	$444.17
27427	Reconstruction knee	CH	T	0052	88.9869	$6,129.06	.	$1,225.82
27428	Reconstruction knee		T	0052	88.9869	$6,129.06	.	$1,225.82
27429	Reconstruction knee		T	0052	88.9869	$6,129.06	.	$1,225.82
27430	Revision of thigh muscles		T	0051	47.3213	$3,259.30	.	$651.86
27435	Incision of knee joint		T	0051	47.3213	$3,259.30	.	$651.86
27437	Revise kneecap		T	0047	39.2855	$2,705.83	.	$541.17
27438	Revise kneecap with implant		T	0048	59.9568	$4,129.58	.	$825.92
27440	Revision of knee joint		T	0047	39.2855	$2,705.83	.	$541.17
27441	Revision of knee joint		T	0047	39.2855	$2,705.83	.	$541.17
27442	Revision of knee joint		T	0047	39.2855	$2,705.83	.	$541.17
27443	Revision of knee joint		T	0047	39.2855	$2,705.83	.	$541.17
27445	Revision of knee joint		C					
27446	Revision of knee joint		T	0425	124.8075	$8,596.24	.	$1,719.25
27447	Total knee arthroplasty		C					
27448	Incision of thigh		C					
27450	Incision of thigh		C					
27454	Realignment of thigh bone		C					
27455	Realignment of knee		C					
27457	Realignment of knee		C					
27465	Shortening of thigh bone		C					
27466	Lengthening of thigh bone		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27468	Shorten/lengthen thighs		C					
27470	Repair of thigh		C					
27472	Repair/graft of thigh		C					
27475	Surgery to stop leg growth		T	0050	32.2439	$2,220.83	.	$444.17
27477	Surgery to stop leg growth		C					
27479	Surgery to stop leg growth		T	0050	32.2439	$2,220.83	.	$444.17
27485	Surgery to stop leg growth		C					
27486	Revise/replace knee joint		C					
27487	Revise/replace knee joint		C					
27488	Removal of knee prosthesis		C					
27495	Reinforce thigh		C					
27496	Decompression of thigh/knee		T	0050	32.2439	$2,220.83	.	$444.17
27497	Decompression of thigh/knee		T	0049	22.9744	$1,582.38	.	$316.48
27498	Decompression of thigh/knee		T	0050	32.2439	$2,220.83	.	$444.17
27499	Decompression of thigh/knee		T	0050	32.2439	$2,220.83	.	$444.17
27500	Treatment of thigh fracture		T	0138	5.5050	$379.16	.	$75.84
27501	Treatment of thigh fracture		T	0129	1.5787	$108.73	.	$21.75
27502	Treatment of thigh fracture		T	0139	20.8356	$1,435.07	.	$287.02
27503	Treatment of thigh fracture		T	0129	1.5787	$108.73	.	$21.75
27506	Treatment of thigh fracture		C					
27507	Treatment of thigh fracture		C					
27508	Treatment of thigh fracture		T	0129	1.5787	$108.73	.	$21.75
27509	Treatment of thigh fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
27510	Treatment of thigh fracture		T	0138	5.5050	$379.16	.	$75.84
27511	Treatment of thigh fracture		C					
27513	Treatment of thigh fracture		C					
27514	Treatment of thigh fracture		C					
27516	Treat thigh fx growth plate		T	0129	1.5787	$108.73	.	$21.75
27517	Treat thigh fx growth plate		T	0129	1.5787	$108.73	.	$21.75
27519	Treat thigh fx growth plate		C					
27520	Treat kneecap fracture		T	0129	1.5787	$108.73	.	$21.75
27524	Treat kneecap fracture		T	0063	48.1318	$3,315.13	.	$663.03
27530	Treat knee fracture		T	0129	1.5787	$108.73	.	$21.75
27532	Treat knee fracture		T	0139	20.8356	$1,435.07	.	$287.02
27535	Treat knee fracture		C					
27536	Treat knee fracture		C					
27538	Treat knee fracture(s)		T	0129	1.5787	$108.73	.	$21.75
27540	Treat knee fracture		C					
27550	Treat knee dislocation		T	0129	1.5787	$108.73	.	$21.75

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27552	Treat knee dislocation		T	0045	15.5512	$1,071.10	$268.44	$214.22
27556	Treat knee dislocation		C					
27557	Treat knee dislocation		C					
27558	Treat knee dislocation		C					
27560	Treat kneecap dislocation		T	0129	1.5787	$108.73	.	$21.75
27562	Treat kneecap dislocation		T	0045	15.5512	$1,071.10	$268.44	$214.22
27566	Treat kneecap dislocation		T	0063	48.1318	$3,315.13	.	$663.03
27570	Fixation of knee joint		T	0045	15.5512	$1,071.10	$268.44	$214.22
27580	Fusion of knee		C					
27590	Amputate leg at thigh		C					
27591	Amputate leg at thigh		C					
27592	Amputate leg at thigh		C					
27594	Amputation follow-up surgery		T	0049	22.9744	$1,582.38	.	$316.48
27596	Amputation follow-up surgery		C					
27598	Amputate lower leg at knee		C					
27599	Leg surgery procedure		T	0129	1.5787	$108.73	.	$21.75
27600	Decompression of lower leg		T	0049	22.9744	$1,582.38	.	$316.48
27601	Decompression of lower leg		T	0049	22.9744	$1,582.38	.	$316.48
27602	Decompression of lower leg		T	0049	22.9744	$1,582.38	.	$316.48
27603	Drain lower leg lesion		T	0008	20.1996	$1,391.27	.	$278.26
27604	Drain lower leg bursa		T	0049	22.9744	$1,582.38	.	$316.48
27605	Incision of achilles tendon		T	0055	22.5951	$1,556.26	$355.34	$311.26
27606	Incision of achilles tendon		T	0049	22.9744	$1,582.38	.	$316.48
27607	Treat lower leg bone lesion		T	0049	22.9744	$1,582.38	.	$316.48
27610	Explore/treat ankle joint		T	0050	32.2439	$2,220.83	.	$444.17
27612	Exploration of ankle joint		T	0050	32.2439	$2,220.83	.	$444.17
27613	Biopsy lower leg soft tissue		T	0020	8.4929	$584.96	.	$117.00
27614	Biopsy lower leg soft tissue		T	0022	23.8986	$1,646.04	$354.45	$329.21
27615	Resect leg/ankle tum < 5 cm		T	0021	18.0784	$1,245.17	.	$249.04
27616	Resect leg/ankle tum 5+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
27618	Exc leg/ankle tum < 3 cm		T	0021	18.0784	$1,245.17	.	$249.04
27619	Exc leg/ankle tum deep <5 cm		T	0021	18.0784	$1,245.17	.	$249.04
27620	Explore/treat ankle joint		T	0050	32.2439	$2,220.83	.	$444.17
27625	Remove ankle joint lining		T	0050	32.2439	$2,220.83	.	$444.17
27626	Remove ankle joint lining		T	0050	32.2439	$2,220.83	.	$444.17
27630	Removal of tendon lesion		T	0049	22.9744	$1,582.38	.	$316.48
27632	Exc leg/ankle les sc 3+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
27634	Exc leg/ankle tum deep 5+ cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
27635	Remove lower leg bone lesion		T	0050	32.2439	$2,220.83	.	$444.17

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27637	Remove/graft leg bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
27638	Remove/graft leg bone lesion		T	0050	32.2439	$2,220.83	.	$444.17
27640	Partial removal of tibia		T	0051	47.3213	$3,259.30	.	$651.86
27641	Partial removal of fibula		T	0050	32.2439	$2,220.83	.	$444.17
27645	Resect tibia tumor		C					
27646	Resect fibula tumor		C					
27647	Resect talus/calcaneus tum		T	0051	47.3213	$3,259.30	.	$651.86
27648	Injection for ankle x-ray		N					
27650	Repair achilles tendon		T	0051	47.3213	$3,259.30	.	$651.86
27652	Repair/graft achilles tendon		T	0052	88.9869	$6,129.06	.	$1,225.82
27654	Repair of achilles tendon		T	0051	47.3213	$3,259.30	.	$651.86
27656	Repair leg fascia defect		T	0049	22.9744	$1,582.38	.	$316.48
27658	Repair of leg tendon each		T	0049	22.9744	$1,582.38	.	$316.48
27659	Repair of leg tendon each		T	0049	22.9744	$1,582.38	.	$316.48
27664	Repair of leg tendon each		T	0050	32.2439	$2,220.83	.	$444.17
27665	Repair of leg tendon each		T	0050	32.2439	$2,220.83	.	$444.17
27675	Repair lower leg tendons		T	0049	22.9744	$1,582.38	.	$316.48
27676	Repair lower leg tendons		T	0050	32.2439	$2,220.83	.	$444.17
27680	Release of lower leg tendon		T	0050	32.2439	$2,220.83	.	$444.17
27681	Release of lower leg tendons		T	0050	32.2439	$2,220.83	.	$444.17
27685	Revision of lower leg tendon		T	0050	32.2439	$2,220.83	.	$444.17
27686	Revise lower leg tendons		T	0050	32.2439	$2,220.83	.	$444.17
27687	Revision of calf tendon		T	0050	32.2439	$2,220.83	.	$444.17
27690	Revise lower leg tendon		T	0051	47.3213	$3,259.30	.	$651.86
27691	Revise lower leg tendon		T	0051	47.3213	$3,259.30	.	$651.86
27692	Revise additional leg tendon		T	0051	47.3213	$3,259.30	.	$651.86
27695	Repair of ankle ligament		T	0050	32.2439	$2,220.83	.	$444.17
27696	Repair of ankle ligaments		T	0050	32.2439	$2,220.83	.	$444.17
27698	Repair of ankle ligament		T	0050	32.2439	$2,220.83	.	$444.17
27700	Revision of ankle joint		T	0047	39.2855	$2,705.83	.	$541.17
27702	Reconstruct ankle joint		C					
27703	Reconstruction ankle joint		C					
27704	Removal of ankle implant		T	0049	22.9744	$1,582.38	.	$316.48
27705	Incision of tibia		T	0051	47.3213	$3,259.30	.	$651.86
27707	Incision of fibula		T	0049	22.9744	$1,582.38	.	$316.48
27709	Incision of tibia & fibula		T	0050	32.2439	$2,220.83	.	$444.17
27712	Realignment of lower leg		C					
27715	Revision of lower leg		C					
27720	Repair of tibia		T	0063	48.1318	$3,315.13	.	$663.03

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27722	Repair/graft of tibia		T	0064	66.9057	$4,608.20	.	$921.64
27724	Repair/graft of tibia		C					
27725	Repair of lower leg		C					
27726	Repair fibula nonunion		T	0063	48.1318	$3,315.13	.	$663.03
27727	Repair of lower leg		C					
27730	Repair of tibia epiphysis		T	0050	32.2439	$2,220.83	.	$444.17
27732	Repair of fibula epiphysis		T	0050	32.2439	$2,220.83	.	$444.17
27734	Repair lower leg epiphyses		T	0050	32.2439	$2,220.83	.	$444.17
27740	Repair of leg epiphyses		T	0050	32.2439	$2,220.83	.	$444.17
27742	Repair of leg epiphyses		T	0051	47.3213	$3,259.30	.	$651.86
27745	Reinforce tibia		T	0052	88.9869	$6,129.06	.	$1,225.82
27750	Treatment of tibia fracture		T	0129	1.5787	$108.73	.	$21.75
27752	Treatment of tibia fracture		T	0139	20.8356	$1,435.07	.	$287.02
27756	Treatment of tibia fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
27758	Treatment of tibia fracture		T	0063	48.1318	$3,315.13	.	$663.03
27759	Treatment of tibia fracture		T	0064	66.9057	$4,608.20	.	$921.64
27760	Cltx medial ankle fx		T	0129	1.5787	$108.73	.	$21.75
27762	Cltx med ankle fx w/mnpj		T	0139	20.8356	$1,435.07	.	$287.02
27766	Optx medial ankle fx		T	0063	48.1318	$3,315.13	.	$663.03
27767	Cltx post ankle fx		T	0129	1.5787	$108.73	.	$21.75
27768	Cltx post ankle fx w/mnpj		T	0129	1.5787	$108.73	.	$21.75
27769	Optx post ankle fx		T	0063	48.1318	$3,315.13	.	$663.03
27780	Treatment of fibula fracture		T	0129	1.5787	$108.73	.	$21.75
27781	Treatment of fibula fracture		T	0139	20.8356	$1,435.07	.	$287.02
27784	Treatment of fibula fracture		T	0063	48.1318	$3,315.13	.	$663.03
27786	Treatment of ankle fracture		T	0129	1.5787	$108.73	.	$21.75
27788	Treatment of ankle fracture		T	0129	1.5787	$108.73	.	$21.75
27792	Treatment of ankle fracture		T	0063	48.1318	$3,315.13	.	$663.03
27808	Treatment of ankle fracture		T	0129	1.5787	$108.73	.	$21.75
27810	Treatment of ankle fracture	CH	T	0129	1.5787	$108.73	.	$21.75
27814	Treatment of ankle fracture		T	0063	48.1318	$3,315.13	.	$663.03
27816	Treatment of ankle fracture		T	0129	1.5787	$108.73	.	$21.75
27818	Treatment of ankle fracture		T	0138	5.5050	$379.16	.	$75.84
27822	Treatment of ankle fracture		T	0063	48.1318	$3,315.13	.	$663.03
27823	Treatment of ankle fracture		T	0064	66.9057	$4,608.20	.	$921.64
27824	Treat lower leg fracture		T	0129	1.5787	$108.73	.	$21.75
27825	Treat lower leg fracture		T	0139	20.8356	$1,435.07	.	$287.02
27826	Treat lower leg fracture		T	0063	48.1318	$3,315.13	.	$663.03
27827	Treat lower leg fracture		T	0064	66.9057	$4,608.20	.	$921.64

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27828	Treat lower leg fracture		T	0064	66.9057	$4,608.20	.	$921.64
27829	Treat lower leg joint		T	0063	48.1318	$3,315.13	.	$663.03
27830	Treat lower leg dislocation		T	0129	1.5787	$108.73	.	$21.75
27831	Treat lower leg dislocation		T	0139	20.8356	$1,435.07	.	$287.02
27832	Treat lower leg dislocation		T	0063	48.1318	$3,315.13	.	$663.03
27840	Treat ankle dislocation	CH	T	0129	1.5787	$108.73	.	$21.75
27842	Treat ankle dislocation		T	0045	15.5512	$1,071.10	$268.44	$214.22
27846	Treat ankle dislocation		T	0063	48.1318	$3,315.13	.	$663.03
27848	Treat ankle dislocation		T	0063	48.1318	$3,315.13	.	$663.03
27860	Fixation of ankle joint		T	0045	15.5512	$1,071.10	$268.44	$214.22
27870	Fusion of ankle joint open		T	0052	88.9869	$6,129.06	.	$1,225.82
27871	Fusion of tibiofibular joint		T	0052	88.9869	$6,129.06	.	$1,225.82
27880	Amputation of lower leg		C					
27881	Amputation of lower leg		C					
27882	Amputation of lower leg		C					
27884	Amputation follow-up surgery		T	0049	22.9744	$1,582.38	.	$316.48
27886	Amputation follow-up surgery		C					
27888	Amputation of foot at ankle		C					
27889	Amputation of foot at ankle		T	0050	32.2439	$2,220.83	.	$444.17
27892	Decompression of leg		T	0050	32.2439	$2,220.83	.	$444.17
27893	Decompression of leg		T	0050	32.2439	$2,220.83	.	$444.17
27894	Decompression of leg		T	0050	32.2439	$2,220.83	.	$444.17
27899	Leg/ankle surgery procedure		T	0129	1.5787	$108.73	.	$21.75
28001	Drainage of bursa of foot		T	0007	13.0129	$896.28	.	$179.26
28002	Treatment of foot infection		T	0049	22.9744	$1,582.38	.	$316.48
28003	Treatment of foot infection		T	0049	22.9744	$1,582.38	.	$316.48
28005	Treat foot bone lesion		T	0055	22.5951	$1,556.26	$355.34	$311.26
28008	Incision of foot fascia		T	0055	22.5951	$1,556.26	$355.34	$311.26
28010	Incision of toe tendon		T	0055	22.5951	$1,556.26	$355.34	$311.26
28011	Incision of toe tendons		T	0055	22.5951	$1,556.26	$355.34	$311.26
28020	Exploration of foot joint		T	0055	22.5951	$1,556.26	$355.34	$311.26
28022	Exploration of foot joint		T	0055	22.5951	$1,556.26	$355.34	$311.26
28024	Exploration of toe joint		T	0055	22.5951	$1,556.26	$355.34	$311.26
28035	Decompression of tibia nerve		T	0220	19.1325	$1,317.77	.	$263.56
28039	Exc foot/toe tum sc > 1.5 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
28041	Exc foot/toe tum deep 1.5cm+		T	0022	23.8986	$1,646.04	$354.45	$329.21
28043	Exc foot/toe tum sc < 1.5 cm		T	0021	18.0784	$1,245.17	.	$249.04
28045	Exc foot/toe tum deep <1.5cm		T	0021	18.0784	$1,245.17	.	$249.04
28046	Resect foot/toe tumor < 3 cm		T	0021	18.0784	$1,245.17	.	$249.04

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28047	Resect foot/toe tumor > 3 cm		T	0022	23.8986	$1,646.04	$354.45	$329.21
28050	Biopsy of foot joint lining		T	0055	22.5951	$1,556.26	$355.34	$311.26
28052	Biopsy of foot joint lining		T	0055	22.5951	$1,556.26	$355.34	$311.26
28054	Biopsy of toe joint lining		T	0055	22.5951	$1,556.26	$355.34	$311.26
28055	Neurectomy foot		T	0220	19.1325	$1,317.77	.	$263.56
28060	Partial removal foot fascia		T	0055	22.5951	$1,556.26	$355.34	$311.26
28062	Removal of foot fascia		T	0055	22.5951	$1,556.26	$355.34	$311.26
28070	Removal of foot joint lining		T	0055	22.5951	$1,556.26	$355.34	$311.26
28072	Removal of foot joint lining		T	0055	22.5951	$1,556.26	$355.34	$311.26
28080	Removal of foot lesion		T	0055	22.5951	$1,556.26	$355.34	$311.26
28086	Excise foot tendon sheath		T	0055	22.5951	$1,556.26	$355.34	$311.26
28088	Excise foot tendon sheath		T	0055	22.5951	$1,556.26	$355.34	$311.26
28090	Removal of foot lesion		T	0055	22.5951	$1,556.26	$355.34	$311.26
28092	Removal of toe lesions		T	0055	22.5951	$1,556.26	$355.34	$311.26
28100	Removal of ankle/heel lesion		T	0055	22.5951	$1,556.26	$355.34	$311.26
28102	Remove/graft foot lesion		T	0056	55.2578	$3,805.94	.	$761.19
28103	Remove/graft foot lesion		T	0056	55.2578	$3,805.94	.	$761.19
28104	Removal of foot lesion		T	0055	22.5951	$1,556.26	$355.34	$311.26
28106	Remove/graft foot lesion		T	0056	55.2578	$3,805.94	.	$761.19
28107	Remove/graft foot lesion		T	0056	55.2578	$3,805.94	.	$761.19
28108	Removal of toe lesions		T	0055	22.5951	$1,556.26	$355.34	$311.26
28110	Part removal of metatarsal		T	0055	22.5951	$1,556.26	$355.34	$311.26
28111	Part removal of metatarsal		T	0055	22.5951	$1,556.26	$355.34	$311.26
28112	Part removal of metatarsal		T	0055	22.5951	$1,556.26	$355.34	$311.26
28113	Part removal of metatarsal		T	0055	22.5951	$1,556.26	$355.34	$311.26
28114	Removal of metatarsal heads		T	0055	22.5951	$1,556.26	$355.34	$311.26
28116	Revision of foot		T	0055	22.5951	$1,556.26	$355.34	$311.26
28118	Removal of heel bone		T	0055	22.5951	$1,556.26	$355.34	$311.26
28119	Removal of heel spur		T	0055	22.5951	$1,556.26	$355.34	$311.26
28120	Part removal of ankle/heel		T	0055	22.5951	$1,556.26	$355.34	$311.26
28122	Partial removal of foot bone		T	0055	22.5951	$1,556.26	$355.34	$311.26
28124	Partial removal of toe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28126	Partial removal of toe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28130	Removal of ankle bone		T	0055	22.5951	$1,556.26	$355.34	$311.26
28140	Removal of metatarsal		T	0055	22.5951	$1,556.26	$355.34	$311.26
28150	Removal of toe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28153	Partial removal of toe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28160	Partial removal of toe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28171	Resect tarsal tumor		T	0055	22.5951	$1,556.26	$355.34	$311.26

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28173	Resect metatarsal tumor		T	0055	22.5951	$1,556.26	$355.34	$311.26
28175	Resect phalanx of toe tumor		T	0055	22.5951	$1,556.26	$355.34	$311.26
28190	Removal of foot foreign body		T	0020	8.4929	$584.96	.	$117.00
28192	Removal of foot foreign body		T	0021	18.0784	$1,245.17	.	$249.04
28193	Removal of foot foreign body		T	0020	8.4929	$584.96	.	$117.00
28200	Repair of foot tendon		T	0055	22.5951	$1,556.26	$355.34	$311.26
28202	Repair/graft of foot tendon		T	0055	22.5951	$1,556.26	$355.34	$311.26
28208	Repair of foot tendon		T	0055	22.5951	$1,556.26	$355.34	$311.26
28210	Repair/graft of foot tendon		T	0056	55.2578	$3,805.94	.	$761.19
28220	Release of foot tendon		T	0055	22.5951	$1,556.26	$355.34	$311.26
28222	Release of foot tendons		T	0055	22.5951	$1,556.26	$355.34	$311.26
28225	Release of foot tendon		T	0055	22.5951	$1,556.26	$355.34	$311.26
28226	Release of foot tendons		T	0055	22.5951	$1,556.26	$355.34	$311.26
28230	Incision of foot tendon(s)		T	0055	22.5951	$1,556.26	$355.34	$311.26
28232	Incision of toe tendon		T	0055	22.5951	$1,556.26	$355.34	$311.26
28234	Incision of foot tendon		T	0055	22.5951	$1,556.26	$355.34	$311.26
28238	Revision of foot tendon		T	0056	55.2578	$3,805.94	.	$761.19
28240	Release of big toe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28250	Revision of foot fascia		T	0055	22.5951	$1,556.26	$355.34	$311.26
28260	Release of midfoot joint		T	0055	22.5951	$1,556.26	$355.34	$311.26
28261	Revision of foot tendon		T	0055	22.5951	$1,556.26	$355.34	$311.26
28262	Revision of foot and ankle		T	0055	22.5951	$1,556.26	$355.34	$311.26
28264	Release of midfoot joint		T	0056	55.2578	$3,805.94	.	$761.19
28270	Release of foot contracture		T	0055	22.5951	$1,556.26	$355.34	$311.26
28272	Release of toe joint each		T	0055	22.5951	$1,556.26	$355.34	$311.26
28280	Fusion of toes		T	0055	22.5951	$1,556.26	$355.34	$311.26
28285	Repair of hammertoe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28286	Repair of hammertoe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28288	Partial removal of foot bone		T	0055	22.5951	$1,556.26	$355.34	$311.26
28289	Repair hallux rigidus		T	0055	22.5951	$1,556.26	$355.34	$311.26
28290	Correction of bunion		T	0057	33.2448	$2,289.77	$475.91	$457.96
28292	Correction of bunion		T	0057	33.2448	$2,289.77	$475.91	$457.96
28293	Correction of bunion		T	0057	33.2448	$2,289.77	$475.91	$457.96
28294	Correction of bunion		T	0057	33.2448	$2,289.77	$475.91	$457.96
28296	Correction of bunion		T	0057	33.2448	$2,289.77	$475.91	$457.96
28297	Correction of bunion		T	0057	33.2448	$2,289.77	$475.91	$457.96
28298	Correction of bunion		T	0057	33.2448	$2,289.77	$475.91	$457.96
28299	Correction of bunion		T	0057	33.2448	$2,289.77	$475.91	$457.96
28300	Incision of heel bone		T	0056	55.2578	$3,805.94	.	$761.19

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28302	Incision of ankle bone		T	0055	22.5951	$1,556.26	$355.34	$311.26
28304	Incision of midfoot bones		T	0056	55.2578	$3,805.94	.	$761.19
28305	Incise/graft midfoot bones		T	0056	55.2578	$3,805.94	.	$761.19
28306	Incision of metatarsal		T	0055	22.5951	$1,556.26	$355.34	$311.26
28307	Incision of metatarsal		T	0055	22.5951	$1,556.26	$355.34	$311.26
28308	Incision of metatarsal		T	0055	22.5951	$1,556.26	$355.34	$311.26
28309	Incision of metatarsals		T	0056	55.2578	$3,805.94	.	$761.19
28310	Revision of big toe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28312	Revision of toe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28313	Repair deformity of toe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28315	Removal of sesamoid bone		T	0055	22.5951	$1,556.26	$355.34	$311.26
28320	Repair of foot bones		T	0056	55.2578	$3,805.94	.	$761.19
28322	Repair of metatarsals		T	0056	55.2578	$3,805.94	.	$761.19
28340	Resect enlarged toe tissue		T	0055	22.5951	$1,556.26	$355.34	$311.26
28341	Resect enlarged toe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28344	Repair extra toe(s)		T	0055	22.5951	$1,556.26	$355.34	$311.26
28345	Repair webbed toe(s)		T	0055	22.5951	$1,556.26	$355.34	$311.26
28360	Reconstruct cleft foot		T	0056	55.2578	$3,805.94	.	$761.19
28400	Treatment of heel fracture		T	0129	1.5787	$108.73	.	$21.75
28405	Treatment of heel fracture		T	0139	20.8356	$1,435.07	.	$287.02
28406	Treatment of heel fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
28415	Treat heel fracture		T	0064	66.9057	$4,608.20	.	$921.64
28420	Treat/graft heel fracture		T	0063	48.1318	$3,315.13	.	$663.03
28430	Treatment of ankle fracture		T	0129	1.5787	$108.73	.	$21.75
28435	Treatment of ankle fracture		T	0129	1.5787	$108.73	.	$21.75
28436	Treatment of ankle fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
28445	Treat ankle fracture		T	0063	48.1318	$3,315.13	.	$663.03
28446	Osteochondral talus autogrft		T	0056	55.2578	$3,805.94	.	$761.19
28450	Treat midfoot fracture each		T	0129	1.5787	$108.73	.	$21.75
28455	Treat midfoot fracture each		T	0129	1.5787	$108.73	.	$21.75
28456	Treat midfoot fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
28465	Treat midfoot fracture each		T	0063	48.1318	$3,315.13	.	$663.03
28470	Treat metatarsal fracture		T	0129	1.5787	$108.73	.	$21.75
28475	Treat metatarsal fracture		T	0129	1.5787	$108.73	.	$21.75
28476	Treat metatarsal fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
28485	Treat metatarsal fracture		T	0063	48.1318	$3,315.13	.	$663.03
28490	Treat big toe fracture		T	0129	1.5787	$108.73	.	$21.75
28495	Treat big toe fracture		T	0129	1.5787	$108.73	.	$21.75
28496	Treat big toe fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28505	Treat big toe fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
28510	Treatment of toe fracture		T	0129	1.5787	$108.73	.	$21.75
28515	Treatment of toe fracture		T	0129	1.5787	$108.73	.	$21.75
28525	Treat toe fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
28530	Treat sesamoid bone fracture		T	0129	1.5787	$108.73	.	$21.75
28531	Treat sesamoid bone fracture		T	0062	26.5543	$1,828.95	$372.87	$365.79
28540	Treat foot dislocation		T	0129	1.5787	$108.73	.	$21.75
28545	Treat foot dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
28546	Treat foot dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
28555	Repair foot dislocation		T	0063	48.1318	$3,315.13	.	$663.03
28570	Treat foot dislocation	CH	T	0129	1.5787	$108.73	.	$21.75
28575	Treat foot dislocation		T	0139	20.8356	$1,435.07	.	$287.02
28576	Treat foot dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
28585	Repair foot dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
28600	Treat foot dislocation		T	0129	1.5787	$108.73	.	$21.75
28605	Treat foot dislocation		T	0129	1.5787	$108.73	.	$21.75
28606	Treat foot dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
28615	Repair foot dislocation		T	0063	48.1318	$3,315.13	.	$663.03
28630	Treat toe dislocation		T	0129	1.5787	$108.73	.	$21.75
28635	Treat toe dislocation		T	0045	15.5512	$1,071.10	$268.44	$214.22
28636	Treat toe dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
28645	Repair toe dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
28660	Treat toe dislocation		T	0129	1.5787	$108.73	.	$21.75
28665	Treat toe dislocation		T	0045	15.5512	$1,071.10	$268.44	$214.22
28666	Treat toe dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
28675	Repair of toe dislocation		T	0062	26.5543	$1,828.95	$372.87	$365.79
28705	Fusion of foot bones		T	0056	55.2578	$3,805.94	.	$761.19
28715	Fusion of foot bones		T	0052	88.9869	$6,129.06	.	$1,225.82
28725	Fusion of foot bones		T	0056	55.2578	$3,805.94	.	$761.19
28730	Fusion of foot bones		T	0056	55.2578	$3,805.94	.	$761.19
28735	Fusion of foot bones		T	0056	55.2578	$3,805.94	.	$761.19
28737	Revision of foot bones		T	0056	55.2578	$3,805.94	.	$761.19
28740	Fusion of foot bones		T	0056	55.2578	$3,805.94	.	$761.19
28750	Fusion of big toe joint		T	0056	55.2578	$3,805.94	.	$761.19
28755	Fusion of big toe joint		T	0055	22.5951	$1,556.26	$355.34	$311.26
28760	Fusion of big toe joint		T	0056	55.2578	$3,805.94	.	$761.19
28800	Amputation of midfoot		C					
28805	Amputation thru metatarsal		T	0055	22.5951	$1,556.26	$355.34	$311.26
28810	Amputation toe & metatarsal		T	0055	22.5951	$1,556.26	$355.34	$311.26

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28820	Amputation of toe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28825	Partial amputation of toe		T	0055	22.5951	$1,556.26	$355.34	$311.26
28890	High energy eswt plantar f		T	0050	32.2439	$2,220.83	.	$444.17
28899	Foot/toes surgery procedure		T	0129	1.5787	$108.73	.	$21.75
29000	Application of body cast		S	0058	1.1201	$77.15	.	$15.43
29010	Application of body cast		S	0426	2.5465	$175.39	.	$35.08
29015	Application of body cast		S	0426	2.5465	$175.39	.	$35.08
29020	Application of body cast		S	0058	1.1201	$77.15	.	$15.43
29025	Application of body cast		S	0058	1.1201	$77.15	.	$15.43
29035	Application of body cast		S	0426	2.5465	$175.39	.	$35.08
29040	Application of body cast		S	0058	1.1201	$77.15	.	$15.43
29044	Application of body cast		S	0426	2.5465	$175.39	.	$35.08
29046	Application of body cast		S	0426	2.5465	$175.39	.	$35.08
29049	Application of figure eight		S	0058	1.1201	$77.15	.	$15.43
29055	Application of shoulder cast		S	0426	2.5465	$175.39	.	$35.08
29058	Application of shoulder cast		S	0058	1.1201	$77.15	.	$15.43
29065	Application of long arm cast		S	0426	2.5465	$175.39	.	$35.08
29075	Application of forearm cast		S	0426	2.5465	$175.39	.	$35.08
29085	Apply hand/wrist cast		S	0058	1.1201	$77.15	.	$15.43
29086	Apply finger cast		S	0058	1.1201	$77.15	.	$15.43
29105	Apply long arm splint		S	0058	1.1201	$77.15	.	$15.43
29125	Apply forearm splint		S	0058	1.1201	$77.15	.	$15.43
29126	Apply forearm splint		S	0058	1.1201	$77.15	.	$15.43
29130	Application of finger splint		S	0058	1.1201	$77.15	.	$15.43
29131	Application of finger splint		S	0058	1.1201	$77.15	.	$15.43
29200	Strapping of chest		S	0058	1.1201	$77.15	.	$15.43
29240	Strapping of shoulder		S	0058	1.1201	$77.15	.	$15.43
29260	Strapping of elbow or wrist		S	0058	1.1201	$77.15	.	$15.43
29280	Strapping of hand or finger		S	0058	1.1201	$77.15	.	$15.43
29305	Application of hip cast		S	0426	2.5465	$175.39	.	$35.08
29325	Application of hip casts		S	0426	2.5465	$175.39	.	$35.08
29345	Application of long leg cast		S	0426	2.5465	$175.39	.	$35.08
29355	Application of long leg cast		S	0426	2.5465	$175.39	.	$35.08
29358	Apply long leg cast brace		S	0426	2.5465	$175.39	.	$35.08
29365	Application of long leg cast		S	0426	2.5465	$175.39	.	$35.08
29405	Apply short leg cast		S	0426	2.5465	$175.39	.	$35.08
29425	Apply short leg cast		S	0426	2.5465	$175.39	.	$35.08
29435	Apply short leg cast		S	0426	2.5465	$175.39	.	$35.08
29440	Addition of walker to cast		S	0058	1.1201	$77.15	.	$15.43

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29445	Apply rigid leg cast		S	0426	2.5465	$175.39	.	$35.08
29450	Application of leg cast		S	0058	1.1201	$77.15	.	$15.43
29505	Application long leg splint		S	0058	1.1201	$77.15	.	$15.43
29515	Application lower leg splint		S	0058	1.1201	$77.15	.	$15.43
29520	Strapping of hip		S	0058	1.1201	$77.15	.	$15.43
29530	Strapping of knee		S	0058	1.1201	$77.15	.	$15.43
29540	Strapping of ankle and/or ft		S	0058	1.1201	$77.15	.	$15.43
29550	Strapping of toes		S	0058	1.1201	$77.15	.	$15.43
29580	Application of paste boot		S	0058	1.1201	$77.15	.	$15.43
29581	Apply multlay comprs lwr leg		S	0058	1.1201	$77.15	.	$15.43
29590	Application of foot splint		S	0058	1.1201	$77.15	.	$15.43
29700	Removal/revision of cast		S	0058	1.1201	$77.15	.	$15.43
29705	Removal/revision of cast		S	0058	1.1201	$77.15	.	$15.43
29710	Removal/revision of cast		S	0426	2.5465	$175.39	.	$35.08
29715	Removal/revision of cast		S	0058	1.1201	$77.15	.	$15.43
29720	Repair of body cast		S	0058	1.1201	$77.15	.	$15.43
29730	Windowing of cast		S	0058	1.1201	$77.15	.	$15.43
29740	Wedging of cast		S	0058	1.1201	$77.15	.	$15.43
29750	Wedging of clubfoot cast		S	0058	1.1201	$77.15	.	$15.43
29799	Casting/strapping procedure		S	0058	1.1201	$77.15	.	$15.43
29800	Jaw arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29804	Jaw arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29805	Shoulder arthroscopy dx		T	0041	29.9672	$2,064.02	.	$412.81
29806	Shoulder arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29807	Shoulder arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29819	Shoulder arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29820	Shoulder arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29821	Shoulder arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29822	Shoulder arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29823	Shoulder arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29824	Shoulder arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29825	Shoulder arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29826	Shoulder arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29827	Arthroscop rotator cuff repr		T	0042	48.4428	$3,336.55	$804.74	$667.31
29828	Arthroscopy biceps tenodesis		T	0042	48.4428	$3,336.55	$804.74	$667.31
29830	Elbow arthroscopy		T	0041	29.9672	$2,064.02	.	$412.81
29834	Elbow arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29835	Elbow arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29836	Elbow arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29837	Elbow arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29838	Elbow arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29840	Wrist arthroscopy		T	0041	29.9672	$2,064.02	.	$412.81
29843	Wrist arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29844	Wrist arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29845	Wrist arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29846	Wrist arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29847	Wrist arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29848	Wrist endoscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29850	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29851	Knee arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29855	Tibial arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29856	Tibial arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29860	Hip arthroscopy dx		T	0042	48.4428	$3,336.55	$804.74	$667.31
29861	Hip arthro w/fb removal		T	0042	48.4428	$3,336.55	$804.74	$667.31
29862	Hip arthr0 w/debridement		T	0042	48.4428	$3,336.55	$804.74	$667.31
29863	Hip arthr0 w/synovectomy		T	0042	48.4428	$3,336.55	$804.74	$667.31
29866	Autgrft implnt knee w/scope		T	0042	48.4428	$3,336.55	$804.74	$667.31
29867	Allgrft implnt knee w/scope		T	0042	48.4428	$3,336.55	$804.74	$667.31
29868	Meniscal trnspl knee w/scpe		T	0042	48.4428	$3,336.55	$804.74	$667.31
29870	Knee arthroscopy dx		T	0041	29.9672	$2,064.02	.	$412.81
29871	Knee arthroscopy/drainage		T	0041	29.9672	$2,064.02	.	$412.81
29873	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29874	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29875	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29876	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29877	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29879	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29880	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29881	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29882	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29883	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29884	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29885	Knee arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29886	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29887	Knee arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29888	Knee arthroscopy/surgery		T	0052	88.9869	$6,129.06	.	$1,225.82
29889	Knee arthroscopy/surgery		T	0052	88.9869	$6,129.06	.	$1,225.82
29891	Ankle arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29892	Ankle arthroscopy/surgery		T	0052	88.9869	$6,129.06	.	$1,225.82
29893	Scope plantar fasciotomy		T	0055	22.5951	$1,556.26	$355.34	$311.26
29894	Ankle arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29895	Ankle arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29897	Ankle arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29898	Ankle arthroscopy/surgery		T	0041	29.9672	$2,064.02	.	$412.81
29899	Ankle arthroscopy/surgery		T	0042	48.4428	$3,336.55	$804.74	$667.31
29900	Mcp joint arthroscopy dx		T	0041	29.9672	$2,064.02	.	$412.81
29901	Mcp joint arthroscopy surg		T	0041	29.9672	$2,064.02	.	$412.81
29902	Mcp joint arthroscopy surg		T	0041	29.9672	$2,064.02	.	$412.81
29904	Subtalar arthro w/fb rmvl		T	0041	29.9672	$2,064.02	.	$412.81
29905	Subtalar arthro w/exc		T	0041	29.9672	$2,064.02	.	$412.81
29906	Subtalar arthro w/deb		T	0041	29.9672	$2,064.02	.	$412.81
29907	Subtalar arthro w/fusion		T	0042	48.4428	$3,336.55	$804.74	$667.31
29914	Hip arthro w/femoroplasty	NI	T	0042	48.4428	$3,336.55	$804.74	$667.31
29915	Hip arthro acetabuloplasty	NI	T	0042	48.4428	$3,336.55	$804.74	$667.31
29916	Hip arthro w/labral repair	NI	T	0042	48.4428	$3,336.55	$804.74	$667.31
29999	Arthroscopy of joint		T	0041	29.9672	$2,064.02	.	$412.81
30000	Drainage of nose lesion		T	0251	3.5538	$244.77	.	$48.96
30020	Drainage of nose lesion		T	0251	3.5538	$244.77	.	$48.96
30100	Intranasal biopsy		T	0252	7.9194	$545.46	$109.16	$109.10
30110	Removal of nose polyp(s)		T	0253	17.3388	$1,194.23	$282.29	$238.85
30115	Removal of nose polyp(s)		T	0253	17.3388	$1,194.23	$282.29	$238.85
30117	Removal of intranasal lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
30118	Removal of intranasal lesion		T	0254	25.6472	$1,766.48	.	$353.30
30120	Revision of nose		T	0254	25.6472	$1,766.48	.	$353.30
30124	Removal of nose lesion		T	0252	7.9194	$545.46	$109.16	$109.10
30125	Removal of nose lesion		T	0256	44.6899	$3,078.06	.	$615.62
30130	Excise inferior turbinate		T	0253	17.3388	$1,194.23	$282.29	$238.85
30140	Resect inferior turbinate		T	0254	25.6472	$1,766.48	.	$353.30
30150	Partial removal of nose		T	0256	44.6899	$3,078.06	.	$615.62
30160	Removal of nose		T	0256	44.6899	$3,078.06	.	$615.62
30200	Injection treatment of nose		T	0252	7.9194	$545.46	$109.16	$109.10
30210	Nasal sinus therapy		T	0252	7.9194	$545.46	$109.16	$109.10
30220	Insert nasal septal button		T	0252	7.9194	$545.46	$109.16	$109.10
30300	Remove nasal foreign body		X	0340	0.6712	$46.23	.	$9.25
30310	Remove nasal foreign body		T	0253	17.3388	$1,194.23	$282.29	$238.85
30320	Remove nasal foreign body		T	0253	17.3388	$1,194.23	$282.29	$238.85
30400	Reconstruction of nose		T	0256	44.6899	$3,078.06	.	$615.62

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
30410	Reconstruction of nose		T	0256	44.6899	$3,078.06	.	$615.62
30420	Reconstruction of nose		T	0256	44.6899	$3,078.06	.	$615.62
30430	Revision of nose		T	0254	25.6472	$1,766.48	.	$353.30
30435	Revision of nose		T	0256	44.6899	$3,078.06	.	$615.62
30450	Revision of nose		T	0256	44.6899	$3,078.06	.	$615.62
30460	Revision of nose		T	0256	44.6899	$3,078.06	.	$615.62
30462	Revision of nose		T	0256	44.6899	$3,078.06	.	$615.62
30465	Repair nasal stenosis		T	0256	44.6899	$3,078.06	.	$615.62
30520	Repair of nasal septum		T	0254	25.6472	$1,766.48	.	$353.30
30540	Repair nasal defect		T	0256	44.6899	$3,078.06	.	$615.62
30545	Repair nasal defect		T	0256	44.6899	$3,078.06	.	$615.62
30560	Release of nasal adhesions		T	0251	3.5538	$244.77	.	$48.96
30580	Repair upper jaw fistula		T	0256	44.6899	$3,078.06	.	$615.62
30600	Repair mouth/nose fistula		T	0256	44.6899	$3,078.06	.	$615.62
30620	Intranasal reconstruction		T	0256	44.6899	$3,078.06	.	$615.62
30630	Repair nasal septum defect		T	0254	25.6472	$1,766.48	.	$353.30
30801	Ablate inf turbinate superf		T	0252	7.9194	$545.46	$109.16	$109.10
30802	Ablate inf turbinate submuc		T	0253	17.3388	$1,194.23	$282.29	$238.85
30901	Control of nosebleed		T	0250	1.1331	$78.04	$25.10	$15.61
30903	Control of nosebleed		T	0250	1.1331	$78.04	$25.10	$15.61
30905	Control of nosebleed		T	0250	1.1331	$78.04	$25.10	$15.61
30906	Repeat control of nosebleed		T	0250	1.1331	$78.04	$25.10	$15.61
30915	Ligation nasal sinus artery		T	0092	27.4530	$1,890.85	.	$378.17
30920	Ligation upper jaw artery		T	0092	27.4530	$1,890.85	.	$378.17
30930	Ther fx nasal inf turbinate		T	0253	17.3388	$1,194.23	$282.29	$238.85
30999	Nasal surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61
31000	Irrigation maxillary sinus		T	0251	3.5538	$244.77	.	$48.96
31002	Irrigation sphenoid sinus		T	0252	7.9194	$545.46	$109.16	$109.10
31020	Exploration maxillary sinus		T	0254	25.6472	$1,766.48	.	$353.30
31030	Exploration maxillary sinus		T	0256	44.6899	$3,078.06	.	$615.62
31032	Explore sinus remove polyps		T	0256	44.6899	$3,078.06	.	$615.62
31040	Exploration behind upper jaw		T	0254	25.6472	$1,766.48	.	$353.30
31050	Exploration sphenoid sinus		T	0256	44.6899	$3,078.06	.	$615.62
31051	Sphenoid sinus surgery		T	0256	44.6899	$3,078.06	.	$615.62
31070	Exploration of frontal sinus		T	0254	25.6472	$1,766.48	.	$353.30
31075	Exploration of frontal sinus		T	0256	44.6899	$3,078.06	.	$615.62
31080	Removal of frontal sinus		T	0256	44.6899	$3,078.06	.	$615.62
31081	Removal of frontal sinus		T	0256	44.6899	$3,078.06	.	$615.62
31084	Removal of frontal sinus		T	0256	44.6899	$3,078.06	.	$615.62

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31085	Removal of frontal sinus		T	0256	44.6899	$3,078.06	.	$615.62
31086	Removal of frontal sinus		T	0256	44.6899	$3,078.06	.	$615.62
31087	Removal of frontal sinus		T	0256	44.6899	$3,078.06	.	$615.62
31090	Exploration of sinuses		T	0256	44.6899	$3,078.06	.	$615.62
31200	Removal of ethmoid sinus		T	0256	44.6899	$3,078.06	.	$615.62
31201	Removal of ethmoid sinus		T	0256	44.6899	$3,078.06	.	$615.62
31205	Removal of ethmoid sinus		T	0256	44.6899	$3,078.06	.	$615.62
31225	Removal of upper jaw		C					
31230	Removal of upper jaw		C					
31231	Nasal endoscopy dx		T	0072	2.0114	$138.54	.	$27.71
31233	Nasal/sinus endoscopy dx		T	0072	2.0114	$138.54	.	$27.71
31235	Nasal/sinus endoscopy dx		T	0074	21.9448	$1,511.47	.	$302.30
31237	Nasal/sinus endoscopy surg		T	0074	21.9448	$1,511.47	.	$302.30
31238	Nasal/sinus endoscopy surg		T	0074	21.9448	$1,511.47	.	$302.30
31239	Nasal/sinus endoscopy surg		T	0075	30.9463	$2,131.46	$445.92	$426.30
31240	Nasal/sinus endoscopy surg		T	0074	21.9448	$1,511.47	.	$302.30
31254	Revision of ethmoid sinus		T	0075	30.9463	$2,131.46	$445.92	$426.30
31255	Removal of ethmoid sinus		T	0075	30.9463	$2,131.46	$445.92	$426.30
31256	Exploration maxillary sinus		T	0075	30.9463	$2,131.46	$445.92	$426.30
31267	Endoscopy maxillary sinus		T	0075	30.9463	$2,131.46	$445.92	$426.30
31276	Sinus endoscopy surgical		T	0075	30.9463	$2,131.46	$445.92	$426.30
31287	Nasal/sinus endoscopy surg		T	0075	30.9463	$2,131.46	$445.92	$426.30
31288	Nasal/sinus endoscopy surg		T	0075	30.9463	$2,131.46	$445.92	$426.30
31290	Nasal/sinus endoscopy surg		C					
31291	Nasal/sinus endoscopy surg		C					
31292	Nasal/sinus endoscopy surg		T	0075	30.9463	$2,131.46	$445.92	$426.30
31293	Nasal/sinus endoscopy surg		T	0075	30.9463	$2,131.46	$445.92	$426.30
31294	Nasal/sinus endoscopy surg		T	0075	30.9463	$2,131.46	$445.92	$426.30
31295	Sinus endo w/balloon dil	NI	T	0075	30.9463	$2,131.46	$445.92	$426.30
31296	Sinus endo w/balloon dil	NI	T	0075	30.9463	$2,131.46	$445.92	$426.30
31297	Sinus endo w/balloon dil	NI	T	0075	30.9463	$2,131.46	$445.92	$426.30
31299	Sinus surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61
31300	Removal of larynx lesion		T	0254	25.6472	$1,766.48	.	$353.30
31320	Diagnostic incision larynx		T	0256	44.6899	$3,078.06	.	$615.62
31360	Removal of larynx		C					
31365	Removal of larynx		C					
31367	Partial removal of larynx		C					
31368	Partial removal of larynx		C					
31370	Partial removal of larynx		C					

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31375	Partial removal of larynx		C					
31380	Partial removal of larynx		C					
31382	Partial removal of larynx		C					
31390	Removal of larynx & pharynx		C					
31395	Reconstruct larynx & pharynx		C					
31400	Revision of larynx		T	0256	44.6899	$3,078.06	.	$615.62
31420	Removal of epiglottis		T	0256	44.6899	$3,078.06	.	$615.62
31500	Insert emergency airway		S	0094	2.3671	$163.04	$45.71	$32.61
31502	Change of windpipe airway		S	0078	1.4318	$98.62	.	$19.73
31505	Diagnostic laryngoscopy		T	0071	0.9297	$64.03	.	$12.81
31510	Laryngoscopy with biopsy		T	0074	21.9448	$1,511.47	.	$302.30
31511	Remove foreign body larynx		T	0072	2.0114	$138.54	.	$27.71
31512	Removal of larynx lesion		T	0074	21.9448	$1,511.47	.	$302.30
31513	Injection into vocal cord		T	0072	2.0114	$138.54	.	$27.71
31515	Laryngoscopy for aspiration		T	0074	21.9448	$1,511.47	.	$302.30
31520	Dx laryngoscopy newborn		T	0072	2.0114	$138.54	.	$27.71
31525	Dx laryngoscopy excl nb		T	0074	21.9448	$1,511.47	.	$302.30
31526	Dx laryngoscopy w/oper scope		T	0074	21.9448	$1,511.47	.	$302.30
31527	Laryngoscopy for treatment		T	0075	30.9463	$2,131.46	$445.92	$426.30
31528	Laryngoscopy and dilation		T	0074	21.9448	$1,511.47	.	$302.30
31529	Laryngoscopy and dilation		T	0074	21.9448	$1,511.47	.	$302.30
31530	Laryngoscopy w/fb removal		T	0074	21.9448	$1,511.47	.	$302.30
31531	Laryngoscopy w/fb & op scope		T	0074	21.9448	$1,511.47	.	$302.30
31535	Laryngoscopy w/biopsy		T	0074	21.9448	$1,511.47	.	$302.30
31536	Laryngoscopy w/bx & op scope		T	0074	21.9448	$1,511.47	.	$302.30
31540	Laryngoscopy w/exc of tumor		T	0074	21.9448	$1,511.47	.	$302.30
31541	Larynscop w/tumr exc + scope		T	0074	21.9448	$1,511.47	.	$302.30
31545	Remove vc lesion w/scope		T	0075	30.9463	$2,131.46	$445.92	$426.30
31546	Remove vc lesion scope/graft		T	0075	30.9463	$2,131.46	$445.92	$426.30
31560	Laryngoscop w/arytenoidectom		T	0075	30.9463	$2,131.46	$445.92	$426.30
31561	Larynscop remve cart + scop		T	0075	30.9463	$2,131.46	$445.92	$426.30
31570	Laryngoscope w/vc inj		T	0074	21.9448	$1,511.47	.	$302.30
31571	Laryngoscop w/vc inj + scope		T	0075	30.9463	$2,131.46	$445.92	$426.30
31575	Diagnostic laryngoscopy		T	0072	2.0114	$138.54	.	$27.71
31576	Laryngoscopy with biopsy		T	0074	21.9448	$1,511.47	.	$302.30
31577	Remove foreign body larynx		T	0073	4.2250	$291.00	$87.83	$58.20
31578	Removal of larynx lesion		T	0075	30.9463	$2,131.46	$445.92	$426.30
31579	Diagnostic laryngoscopy		T	0073	4.2250	$291.00	$87.83	$58.20
31580	Revision of larynx		T	0256	44.6899	$3,078.06	.	$615.62

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31582	Revision of larynx		T	0256	44.6899	$3,078.06	.	$615.62
31584	Treat larynx fracture		C					
31587	Revision of larynx		C					
31588	Revision of larynx		T	0256	44.6899	$3,078.06	.	$615.62
31590	Reinnervate larynx		T	0256	44.6899	$3,078.06	.	$615.62
31595	Larynx nerve surgery		T	0256	44.6899	$3,078.06	.	$615.62
31599	Larynx surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61
31600	Incision of windpipe		T	0254	25.6472	$1,766.48	.	$353.30
31601	Incision of windpipe		T	0254	25.6472	$1,766.48	.	$353.30
31603	Incision of windpipe		T	0252	7.9194	$545.46	$109.16	$109.10
31605	Incision of windpipe		T	0252	7.9194	$545.46	$109.16	$109.10
31610	Incision of windpipe		T	0254	25.6472	$1,766.48	.	$353.30
31611	Surgery/speech prosthesis		T	0254	25.6472	$1,766.48	.	$353.30
31612	Puncture/clear windpipe		T	0254	25.6472	$1,766.48	.	$353.30
31613	Repair windpipe opening		T	0254	25.6472	$1,766.48	.	$353.30
31614	Repair windpipe opening		T	0256	44.6899	$3,078.06	.	$615.62
31615	Visualization of windpipe		T	0252	7.9194	$545.46	$109.16	$109.10
31620	Endobronchial us add-on		N					
31622	Dx bronchoscope/wash		T	0076	10.5006	$723.24	$189.82	$144.65
31623	Dx bronchoscope/brush		T	0076	10.5006	$723.24	$189.82	$144.65
31624	Dx bronchoscope/lavage		T	0076	10.5006	$723.24	$189.82	$144.65
31625	Bronchoscopy w/biopsy(s)		T	0076	10.5006	$723.24	$189.82	$144.65
31626	Bronchoscopy w/markers		T	0076	10.5006	$723.24	$189.82	$144.65
31627	Navigational bronchoscopy		N					
31628	Bronchoscopy/lung bx each		T	0076	10.5006	$723.24	$189.82	$144.65
31629	Bronchoscopy/needle bx each		T	0076	10.5006	$723.24	$189.82	$144.65
31630	Bronchoscopy dilate/fx repr		T	0415	28.6278	$1,971.77	$459.92	$394.36
31631	Bronchoscopy dilate w/stent		T	0415	28.6278	$1,971.77	$459.92	$394.36
31632	Bronchoscopy/lung bx addl		T	0076	10.5006	$723.24	$189.82	$144.65
31633	Bronchoscopy/needle bx addl		T	0076	10.5006	$723.24	$189.82	$144.65
31634	Bronch w/balloon occlusion	NI	T	0076	10.5006	$723.24	$189.82	$144.65
31635	Bronchoscopy w/fb removal		T	0076	10.5006	$723.24	$189.82	$144.65
31636	Bronchoscopy bronch stents		T	0415	28.6278	$1,971.77	$459.92	$394.36
31637	Bronchoscopy stent add-on		T	0076	10.5006	$723.24	$189.82	$144.65
31638	Bronchoscopy revise stent		T	0415	28.6278	$1,971.77	$459.92	$394.36
31640	Bronchoscopy w/tumor excise		T	0415	28.6278	$1,971.77	$459.92	$394.36
31641	Bronchoscopy treat blockage		T	0415	28.6278	$1,971.77	$459.92	$394.36
31643	Diag bronchoscope/catheter		T	0076	10.5006	$723.24	$189.82	$144.65
31645	Bronchoscopy clear airways		T	0076	10.5006	$723.24	$189.82	$144.65

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31646	Bronchoscopy reclear airway		T	0076	10.5006	$723.24	$189.82	$144.65
31656	Bronchoscopy inj for x-ray		T	0076	10.5006	$723.24	$189.82	$144.65
31715	Injection for bronchus x-ray		N					
31717	Bronchial brush biopsy		T	0073	4.2250	$291.00	$67.83	$58.20
31720	Clearance of airways		S	0077	0.4171	$28.73	$7.74	$5.75
31725	Clearance of airways		C					
31730	Intro windpipe wire/tube		T	0073	4.2250	$291.00	$67.83	$58.20
31750	Repair of windpipe		T	0256	44.6899	$3,078.06	.	$615.62
31755	Repair of windpipe		T	0256	44.6899	$3,078.06	.	$615.62
31760	Repair of windpipe		C					
31766	Reconstruction of windpipe		C					
31770	Repair/graft of bronchus		C					
31775	Reconstruct bronchus		C					
31780	Reconstruct windpipe		C					
31781	Reconstruct windpipe		C					
31785	Remove windpipe lesion		T	0254	25.6472	$1,766.48	.	$353.30
31786	Remove windpipe lesion		C					
31800	Repair of windpipe injury		C					
31805	Repair of windpipe injury		C					
31820	Closure of windpipe lesion		T	0254	25.6472	$1,766.48	.	$353.30
31825	Repair of windpipe defect		T	0254	25.6472	$1,766.48	.	$353.30
31830	Revise windpipe scar		T	0254	25.6472	$1,766.48	.	$353.30
31899	Airways surgical procedure		T	0076	10.5006	$723.24	$189.82	$144.65
32035	Exploration of chest		C					
32036	Exploration of chest		C					
32095	Biopsy through chest wall		C					
32100	Exploration/biopsy of chest		C					
32110	Explore/repair chest		C					
32120	Re-exploration of chest		C					
32124	Explore chest free adhesions		C					
32140	Removal of lung lesion(s)		C					
32141	Remove/treat lung lesions		C					
32150	Removal of lung lesion(s)		C					
32151	Remove lung foreign body		C					
32160	Open chest heart massage		C					
32200	Drain open lung lesion		C					
32201	Drain percut lung lesion		T	0070	5.5631	$383.16	.	$76.64
32215	Treat chest lining		C					
32220	Release of lung		C					

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32225	Partial release of lung		C					
32310	Removal of chest lining		C					
32320	Free/remove chest lining		C					
32400	Needle biopsy chest lining		T	0685	9.7353	$670.53	.	$134.11
32402	Open biopsy chest lining		C					
32405	Biopsy lung or mediastinum		T	0685	9.7353	$670.53	.	$134.11
32420	Puncture/clear lung		T	0070	5.5631	$383.16	.	$76.64
32421	Thoracentesis for aspiration		T	0070	5.5631	$383.16	.	$76.64
32422	Thoracentesis w/tube insert		T	0070	5.5631	$383.16	.	$76.64
32440	Removal of lung		C					
32442	Sleeve pneumonectomy		C					
32445	Removal of lung		C					
32480	Partial removal of lung		C					
32482	Bilobectomy		C					
32484	Segmentectomy		C					
32486	Sleeve lobectomy		C					
32488	Completion pneumonectomy		C					
32491	Lung volume reduction		C					
32500	Partial removal of lung		C					
32501	Repair bronchus add-on		C					
32503	Resect apical lung tumor		C					
32504	Resect apical lung tum/chest		C					
32540	Removal of lung lesion		C					
32550	Insert pleural cath		T	0652	31.0010	$2,135.22	.	$427.05
32551	Insertion of chest tube		T	0070	5.5631	$383.16	.	$76.64
32552	Remove lung catheter		S	0078	1.4318	$98.62	.	$19.73
32553	Ins mark thor for rt perq		X	0310	13.4552	$926.74	$325.27	$185.35
32560	Treat pleurodesis w/agent		T	0070	5.5631	$383.16	.	$76.64
32561	Lyse chest fibrin init day		T	0070	5.5631	$383.16	.	$76.64
32562	Lyse chest fibrin subq day		T	0070	5.5631	$383.16	.	$76.64
32601	Thoracoscopy diagnostic		T	0069	34.8422	$2,399.79	$591.64	$479.96
32602	Thoracoscopy diagnostic		T	0069	34.8422	$2,399.79	$591.64	$479.96
32603	Thoracoscopy diagnostic		T	0069	34.8422	$2,399.79	$591.64	$479.96
32604	Thoracoscopy diagnostic		T	0069	34.8422	$2,399.79	$591.64	$479.96
32605	Thoracoscopy diagnostic		T	0069	34.8422	$2,399.79	$591.64	$479.96
32606	Thoracoscopy diagnostic		T	0069	34.8422	$2,399.79	$591.64	$479.96
32650	Thoracoscopy surgical		C					
32651	Thoracoscopy surgical		C					
32652	Thoracoscopy surgical		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32653	Thoracoscopy surgical		C					
32654	Thoracoscopy surgical		C					
32655	Thoracoscopy surgical		C					
32656	Thoracoscopy surgical		C					
32657	Thoracoscopy surgical		C					
32658	Thoracoscopy surgical		C					
32659	Thoracoscopy surgical		C					
32660	Thoracoscopy surgical		C					
32661	Thoracoscopy surgical		C					
32662	Thoracoscopy surgical		C					
32663	Thoracoscopy surgical		C					
32664	Thoracoscopy surgical		C					
32665	Thoracoscopy surgical		C					
32800	Repair lung hernia		C					
32810	Close chest after drainage		C					
32815	Close bronchial fistula		C					
32820	Reconstruct injured chest		C					
32850	Donor pneumonectomy		C					
32851	Lung transplant single		C					
32852	Lung transplant with bypass		C					
32853	Lung transplant double		C					
32854	Lung transplant with bypass		C					
32855	Prepare donor lung single		C					
32856	Prepare donor lung double		C					
32900	Removal of rib(s)		C					
32905	Revise & repair chest wall		C					
32906	Revise & repair chest wall		C					
32940	Revision of lung		C					
32960	Therapeutic pneumothorax		T	0070	5.5631	$383.16	.	$76.64
32997	Total lung lavage		C					
32998	Perq rf ablate tx pul tumor		T	0423	56.5664	$3,896.07	.	$779.22
32999	Chest surgery procedure		T	0070	5.5631	$383.16	.	$76.64
33010	Drainage of heart sac		T	0070	5.5631	$383.16	.	$76.64
33011	Repeat drainage of heart sac		T	0070	5.5631	$383.16	.	$76.64
33015	Incision of heart sac		C					
33020	Incision of heart sac		C					
33025	Incision of heart sac		C					
33030	Partial removal of heart sac		C					
33031	Partial removal of heart sac		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33050	Removal of heart sac lesion		C					
33120	Removal of heart lesion		C					
33130	Removal of heart lesion		C					
33140	Heart revascularize (tmr)		C					
33141	Heart tmr w/other procedure		C					
33202	Insert epicard eltrd open		C					
33203	Insert epicard eltrd endo		C					
33206	Insertion of heart pacemaker		T	0089	113.4179	$7,811.77	$1,643.98	$1,562.36
33207	Insertion of heart pacemaker		T	0089	113.4179	$7,811.77	$1,643.98	$1,562.36
33208	Insertion of heart pacemaker		T	0655	137.7042	$9,484.51	.	$1,896.91
33210	Insertion of heart electrode		T	0106	52.2139	$3,596.28	.	$719.26
33211	Insertion of heart electrode		T	0106	52.2139	$3,596.28	.	$719.26
33212	Insertion of pulse generator		T	0090	95.5918	$6,583.98	$1,593.50	$1,316.80
33213	Insertion of pulse generator		T	0654	108.0987	$7,445.41	.	$1,489.09
33214	Upgrade of pacemaker system		T	0655	137.7042	$9,484.51	.	$1,896.91
33215	Reposition pacing-defib lead		T	0105	22.7342	$1,565.84	.	$313.17
33216	Insert 1 electrode pm-defib		T	0106	52.2139	$3,596.28	.	$719.26
33217	Insert 2 electrode pm-defib		T	0106	52.2139	$3,596.28	.	$719.26
33218	Repair lead pace-defib one		T	0105	22.7342	$1,565.84	.	$313.17
33220	Repair lead pace-defib dual		T	0105	22.7342	$1,565.84	.	$313.17
33222	Revise pocket pacemaker		T	0136	17.2117	$1,185.47	.	$237.10
33223	Revise pocket for defib		T	0136	17.2117	$1,185.47	.	$237.10
33224	Insert pacing lead & connect		T	0418	154.3377	$10,630.16	.	$2,126.04
33225	L ventric pacing lead add-on		T	0418	154.3377	$10,630.16	.	$2,126.04
33226	Reposition l ventric lead		T	0105	22.7342	$1,565.84	.	$313.17
33233	Removal of pacemaker system		T	0105	22.7342	$1,565.84	.	$313.17
33234	Removal of pacemaker system		T	0105	22.7342	$1,565.84	.	$313.17
33235	Removal pacemaker electrode		T	0105	22.7342	$1,565.84	.	$313.17
33236	Remove electrode/thoracotomy		C					
33237	Remove electrode/thoracotomy		C					
33238	Remove electrode/thoracotomy		C					
33240	Insert pulse generator		T	0107	339.8079	$23,404.61	.	$4,680.93
33241	Remove pulse generator		T	0105	22.7342	$1,565.84	.	$313.17
33243	Remove eltrd/thoracotomy		C					
33244	Remove eltrd transven		T	0105	22.7342	$1,565.84	.	$313.17
33249	Eltrd/insert pace-defib		T	0108	389.5350	$26,829.61	.	$5,365.93
33250	Ablate heart dysrhythm focus		C					
33251	Ablate heart dysrhythm focus		C					
33254	Ablate atria lmtd		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33255	Ablate atria w/o bypass ext		C					
33256	Ablate atria w/bypass exten		C					
33257	Ablate atria lmtd add-on		C					
33258	Ablate atria x10sv add-on		C					
33259	Ablate atria w/bypass add-on		C					
33261	Ablate heart dysrhythm focus		C					
33265	Ablate atria lmtd endo		C					
33266	Ablate atria x10sv endo		C					
33282	Implant pat-active ht record		S	0680	78.3883	$5,399.07	.	$1,079.82
33284	Remove pat-active ht record		T	0020	8.4929	$584.96	.	$117.00
33300	Repair of heart wound		C					
33305	Repair of heart wound		C					
33310	Exploratory heart surgery		C					
33315	Exploratory heart surgery		C					
33320	Repair major blood vessel(s)		C					
33321	Repair major vessel		C					
33322	Repair major blood vessel(s)		C					
33330	Insert major vessel graft		C					
33332	Insert major vessel graft		C					
33335	Insert major vessel graft		C					
33400	Repair of aortic valve		C					
33401	Valvuloplasty open		C					
33403	Valvuloplasty w/cp bypass		C					
33404	Prepare heart-aorta conduit		C					
33405	Replacement of aortic valve		C					
33406	Replacement of aortic valve		C					
33410	Replacement of aortic valve		C					
33411	Replacement of aortic valve		C					
33412	Replacement of aortic valve		C					
33413	Replacement of aortic valve		C					
33414	Repair of aortic valve		C					
33415	Revision subvalvular tissue		C					
33416	Revise ventricle muscle		C					
33417	Repair of aortic valve		C					
33420	Revision of mitral valve		C					
33422	Revision of mitral valve		C					
33425	Repair of mitral valve		C					
33426	Repair of mitral valve		C					
33427	Repair of mitral valve		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33430	Replacement of mitral valve		C					
33460	Revision of tricuspid valve		C					
33463	Valvuloplasty tricuspid		C					
33464	Valvuloplasty tricuspid		C					
33465	Replace tricuspid valve		C					
33468	Revision of tricuspid valve		C					
33470	Revision of pulmonary valve		C					
33471	Valvotomy pulmonary valve		C					
33472	Revision of pulmonary valve		C					
33474	Revision of pulmonary valve		C					
33475	Replacement pulmonary valve		C					
33476	Revision of heart chamber		C					
33478	Revision of heart chamber		C					
33496	Repair prosth valve clot		C					
33500	Repair heart vessel fistula		C					
33501	Repair heart vessel fistula		C					
33502	Coronary artery correction		C					
33503	Coronary artery graft		C					
33504	Coronary artery graft		C					
33505	Repair artery w/tunnel		C					
33506	Repair artery translocation		C					
33507	Repair art intramural		C					
33508	Endoscopic vein harvest		N					
33510	Cabg vein single		C					
33511	Cabg vein two		C					
33512	Cabg vein three		C					
33513	Cabg vein four		C					
33514	Cabg vein five		C					
33516	Cabg vein six or more		C					
33517	Cabg artery-vein single		C					
33518	Cabg artery-vein two		C					
33519	Cabg artery-vein three		C					
33521	Cabg artery-vein four		C					
33522	Cabg artery-vein five		C					
33523	Cabg art-vein six or more		C					
33530	Coronary artery bypass/reop		C					
33533	Cabg arterial single		C					
33534	Cabg arterial two		C					
33535	Cabg arterial three		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33536	Cabg arterial four or more		C					
33542	Removal of heart lesion		C					
33545	Repair of heart damage		C					
33548	Restore/remodel ventricle		C					
33572	Open coronary endarterectomy		C					
33600	Closure of valve		C					
33602	Closure of valve		C					
33606	Anastomosis/artery-aorta		C					
33608	Repair anomaly w/conduit		C					
33610	Repair by enlargement		C					
33611	Repair double ventricle		C					
33612	Repair double ventricle		C					
33615	Repair modified fontan		C					
33617	Repair single ventricle		C					
33619	Repair single ventricle		C					
33620	Apply r&l pulm art bands	NI	C					
33621	Transthor cath for stent	NI	C					
33622	Redo compl cardiac anomaly	NI	C					
33641	Repair heart septum defect		C					
33645	Revision of heart veins		C					
33647	Repair heart septum defects		C					
33660	Repair of heart defects		C					
33665	Repair of heart defects		C					
33670	Repair of heart chambers		C					
33675	Close mult vsd		C					
33676	Close mult vsd w/resection		C					
33677	Cl mult vsd w/rem pul band		C					
33681	Repair heart septum defect		C					
33684	Repair heart septum defect		C					
33688	Repair heart septum defect		C					
33690	Reinforce pulmonary artery		C					
33692	Repair of heart defects		C					
33694	Repair of heart defects		C					
33697	Repair of heart defects		C					
33702	Repair of heart defects		C					
33710	Repair of heart defects		C					
33720	Repair of heart defect		C					
33722	Repair of heart defect		C					
33724	Repair venous anomaly		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33726	Repair pul venous stenosis		C					
33730	Repair heart-vein defect(s)		C					
33732	Repair heart-vein defect		C					
33735	Revision of heart chamber		C					
33736	Revision of heart chamber		C					
33737	Revision of heart chamber		C					
33750	Major vessel shunt		C					
33755	Major vessel shunt		C					
33762	Major vessel shunt		C					
33764	Major vessel shunt & graft		C					
33766	Major vessel shunt		C					
33767	Major vessel shunt		C					
33768	Cavopulmonary shunting		C					
33770	Repair great vessels defect		C					
33771	Repair great vessels defect		C					
33774	Repair great vessels defect		C					
33775	Repair great vessels defect		C					
33776	Repair great vessels defect		C					
33777	Repair great vessels defect		C					
33778	Repair great vessels defect		C					
33779	Repair great vessels defect		C					
33780	Repair great vessels defect		C					
33781	Repair great vessels defect		C					
33782	Nikaidoh proc		C					
33783	Nikaidoh proc w/ostia implt		C					
33786	Repair arterial trunk		C					
33788	Revision of pulmonary artery		C					
33800	Aortic suspension		C					
33802	Repair vessel defect		C					
33803	Repair vessel defect		C					
33813	Repair septal defect		C					
33814	Repair septal defect		C					
33820	Revise major vessel		C					
33822	Revise major vessel		C					
33824	Revise major vessel		C					
33840	Remove aorta constriction		C					
33845	Remove aorta constriction		C					
33851	Remove aorta constriction		C					
33852	Repair septal defect		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33853	Repair septal defect		C					
33860	Ascending aortic graft		C					
33861	Ascending aortic graft	CH	D					
33863	Ascending aortic graft		C					
33864	Ascending aortic graft		C					
33870	Transverse aortic arch graft		C					
33875	Thoracic aortic graft		C					
33877	Thoracoabdominal graft		C					
33880	Endovasc taa repr incl subcl		C					
33881	Endovasc taa repr w/o subcl		C					
33883	Insert endovasc prosth taa		C					
33884	Endovasc prosth taa add-on		C					
33886	Endovasc prosth delayed		C					
33889	Artery transpose/endovas taa		C					
33891	Car-car bp grft/endovas taa		C					
33910	Remove lung artery emboli		C					
33915	Remove lung artery emboli		C					
33916	Surgery of great vessel		C					
33917	Repair pulmonary artery		C					
33920	Repair pulmonary atresia		C					
33922	Transect pulmonary artery		C					
33924	Remove pulmonary shunt		C					
33925	Rpr pul art unifocal w/o cpb		C					
33926	Repr pul art unifocal w/cpb		C					
33930	Removal of donor heart/lung		C					
33933	Prepare donor heart/lung		C					
33935	Transplantation heart/lung		C					
33940	Removal of donor heart		C					
33944	Prepare donor heart		C					
33945	Transplantation of heart		C					
33960	External circulation assist		C					
33961	External circulation assist		C					
33967	Insert ia percut device		C					
33968	Remove aortic assist device		C					
33970	Aortic circulation assist		C					
33971	Aortic circulation assist		C					
33973	Insert balloon device		C					
33974	Remove intra-aortic balloon		C					
33975	Implant ventricular device		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33976	Implant ventricular device		C					
33977	Remove ventricular device		C					
33978	Remove ventricular device		C					
33979	Insert intracorporeal device		C					
33980	Remove intracorporeal device		C					
33981	Replace vad pump ext		C					
33982	Replace vad intra w/o bp		C					
33983	Replace vad intra w/bp		C					
33999	Cardiac surgery procedure		T	0070	5.5631	$383.16	.	$76.64
34001	Removal of artery clot		C					
34051	Removal of artery clot		C					
34101	Removal of artery clot		T	0088	41.7208	$2,873.56	$655.22	$574.72
34111	Removal of arm artery clot		T	0088	41.7208	$2,873.56	$655.22	$574.72
34151	Removal of artery clot		C					
34201	Removal of artery clot		T	0088	41.7208	$2,873.56	$655.22	$574.72
34203	Removal of leg artery clot		T	0088	41.7208	$2,873.56	$655.22	$574.72
34401	Removal of vein clot		C					
34421	Removal of vein clot		T	0088	41.7208	$2,873.56	$655.22	$574.72
34451	Removal of vein clot		C					
34471	Removal of vein clot		T	0088	41.7208	$2,873.56	$655.22	$574.72
34490	Removal of vein clot		T	0088	41.7208	$2,873.56	$655.22	$574.72
34501	Repair valve femoral vein		T	0088	41.7208	$2,873.56	$655.22	$574.72
34502	Reconstruct vena cava		C					
34510	Transposition of vein valve		T	0088	41.7208	$2,873.56	$655.22	$574.72
34520	Cross-over vein graft		T	0088	41.7208	$2,873.56	$655.22	$574.72
34530	Leg vein fusion		T	0088	41.7208	$2,873.56	$655.22	$574.72
34800	Endovas aaa repr w/sm tube		C					
34802	Endovas aaa repr w/2-p part		C					
34803	Endovas aaa repr w/3-p part		C					
34804	Endovas aaa repr w/1-p part		C					
34805	Endovas aaa repr w/long tube		C					
34806	Aneurysm press sensor add-on		C					
34808	Endovas iliac a device addon		C					
34812	Xpose for endoprosth femorl		C					
34813	Femoral endovas graft add-on		C					
34820	Xpose for endoprosth iliac		C					
34825	Endovasc extend prosth init		C					
34826	Endovasc exten prosth addl		C					
34830	Open aortic tube prosth repr		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
34831	Open aortoiliac prosth repr		C					
34832	Open aortofemor prosth repr		C					
34833	Xpose for endoprosth iliac		C					
34834	Xpose endoprosth brachial		C					
34900	Endovasc iliac repr w/graft		C					
35001	Repair defect of artery		C					
35002	Repair artery rupture neck		C					
35005	Repair defect of artery		C					
35011	Repair defect of artery		T	0653	45.1001	$3,106.31	.	$621.27
35013	Repair artery rupture arm		C					
35021	Repair defect of artery		C					
35022	Repair artery rupture chest		C					
35045	Repair defect of arm artery		C					
35081	Repair defect of artery		C					
35082	Repair artery rupture aorta		C					
35091	Repair defect of artery		C					
35092	Repair artery rupture aorta		C					
35102	Repair defect of artery		C					
35103	Repair artery rupture groin		C					
35111	Repair defect of artery		C					
35112	Repair artery rupture spleen		C					
35121	Repair defect of artery		C					
35122	Repair artery rupture belly		C					
35131	Repair defect of artery		C					
35132	Repair artery rupture groin		C					
35141	Repair defect of artery		C					
35142	Repair artery rupture thigh		C					
35151	Repair defect of artery		C					
35152	Repair artery rupture knee		C					
35180	Repair blood vessel lesion		T	0093	36.4868	$2,513.06	.	$502.62
35182	Repair blood vessel lesion		C					
35184	Repair blood vessel lesion		T	0093	36.4868	$2,513.06	.	$502.62
35188	Repair blood vessel lesion		T	0088	41.7208	$2,873.56	$655.22	$574.72
35189	Repair blood vessel lesion		C					
35190	Repair blood vessel lesion		T	0093	36.4868	$2,513.06	.	$502.62
35201	Repair blood vessel lesion		T	0093	36.4868	$2,513.06	.	$502.62
35206	Repair blood vessel lesion		T	0093	36.4868	$2,513.06		$502.62
35207	Repair blood vessel lesion		T	0088	41.7208	$2,873.56	$655.22	$574.72
35211	Repair blood vessel lesion		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35216	Repair blood vessel lesion		C					
35221	Repair blood vessel lesion		C					
35226	Repair blood vessel lesion		T	0020	8.4929	$584.96	.	$117.00
35231	Repair blood vessel lesion		T	0093	36.4868	$2,513.06	.	$502.62
35236	Repair blood vessel lesion		T	0093	36.4868	$2,513.06	.	$502.62
35241	Repair blood vessel lesion		C					
35246	Repair blood vessel lesion		C					
35251	Repair blood vessel lesion		C					
35256	Repair blood vessel lesion		T	0093	36.4868	$2,513.06	.	$502.62
35261	Repair blood vessel lesion		T	0653	45.1001	$3,106.31	.	$621.27
35266	Repair blood vessel lesion		T	0653	45.1001	$3,106.31	.	$621.27
35271	Repair blood vessel lesion		C					
35276	Repair blood vessel lesion		C					
35281	Repair blood vessel lesion		C					
35286	Repair blood vessel lesion		T	0653	45.1001	$3,106.31	.	$621.27
35301	Rechanneling of artery		C					
35302	Rechanneling of artery		C					
35303	Rechanneling of artery		C					
35304	Rechanneling of artery		C					
35305	Rechanneling of artery		C					
35306	Rechanneling of artery		C					
35311	Rechanneling of artery		C					
35321	Rechanneling of artery		T	0093	36.4868	$2,513.06	.	$502.62
35331	Rechanneling of artery		C					
35341	Rechanneling of artery		C					
35351	Rechanneling of artery		C					
35355	Rechanneling of artery		C					
35361	Rechanneling of artery		C					
35363	Rechanneling of artery		C					
35371	Rechanneling of artery		C					
35372	Rechanneling of artery		C					
35390	Reoperation carotid add-on		C					
35400	Angioscopy		C					
35450	Repair arterial blockage		C					
35452	Repair arterial blockage		C					
35454	Repair arterial blockage	CH	D					
35456	Repair arterial blockage	CH	D					
35458	Repair arterial blockage		T	0083	54.8838	$3,780.18	.	$756.04
35459	Repair arterial blockage	CH	D					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35460	Repair venous blockage		T	0083	54.8838	$3,780.18	.	$756.04
35470	Repair arterial blockage	CH	D					
35471	Repair arterial blockage		T	0083	54.8838	$3,780.18	.	$756.04
35472	Repair arterial blockage		T	0083	54.8838	$3,780.18	.	$756.04
35473	Repair arterial blockage	CH	D					
35474	Repair arterial blockage	CH	D					
35475	Repair arterial blockage		T	0083	54.8838	$3,780.18	.	$756.04
35476	Repair venous blockage		T	0083	54.8838	$3,780.18	.	$756.04
35480	Atherectomy, open	CH	D					
35481	Atherectomy, open	CH	D					
35482	Atherectomy, open	CH	D					
35483	Atherectomy, open	CH	D					
35484	Atherectomy, open	CH	D					
35485	Atherectomy, open	CH	D					
35490	Atherectomy, percutaneous	CH	D					
35491	Atherectomy, percutaneous	CH	D					
35492	Atherectomy, percutaneous	CH	D					
35493	Atherectomy, percutaneous	CH	D					
35494	Atherectomy, percutaneous	CH	D					
35495	Atherectomy, percutaneous	CH	D					
35500	Harvest vein for bypass		T	0103	19.1361	$1,318.02	.	$263.61
35501	Artery bypass graft		C					
35506	Artery bypass graft		C					
35508	Artery bypass graft		C					
35509	Artery bypass graft		C					
35510	Artery bypass graft		C					
35511	Artery bypass graft		C					
35512	Artery bypass graft		C					
35515	Artery bypass graft		C					
35516	Artery bypass graft		C					
35518	Artery bypass graft		C					
35521	Artery bypass graft		C					
35522	Artery bypass graft		C					
35523	Artery bypass graft		C					
35525	Artery bypass graft		C					
35526	Artery bypass graft		C					
35531	Artery bypass graft		C					
35533	Artery bypass graft		C					
35535	Artery bypass graft		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35536	Artery bypass graft		C					
35537	Artery bypass graft		C					
35538	Artery bypass graft		C					
35539	Artery bypass graft		C					
35540	Artery bypass graft		C					
35548	Artery bypass graft		C					
35549	Artery bypass graft		C					
35551	Artery bypass graft		C					
35556	Artery bypass graft		C					
35558	Artery bypass graft		C					
35560	Artery bypass graft		C					
35563	Artery bypass graft		C					
35565	Artery bypass graft		C					
35566	Artery bypass graft		C					
35570	Artery bypass graft		C					
35571	Artery bypass graft		C					
35572	Harvest femoropopliteal vein		N					
35583	Vein bypass graft		C					
35585	Vein bypass graft		C					
35587	Vein bypass graft		C					
35600	Harvest art for cabg add-on		C					
35601	Artery bypass graft		C					
35606	Artery bypass graft		C					
35612	Artery bypass graft		C					
35616	Artery bypass graft		C					
35621	Artery bypass graft		C					
35623	Bypass graft not vein		C					
35626	Artery bypass graft		C					
35631	Artery bypass graft		C					
35632	Artery bypass graft		C					
35633	Artery bypass graft		C					
35634	Artery bypass graft		C					
35636	Artery bypass graft		C					
35637	Artery bypass graft		C					
35638	Artery bypass graft		C					
35642	Artery bypass graft		C					
35645	Artery bypass graft		C					
35646	Artery bypass graft		C					
35647	Artery bypass graft		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35650	Artery bypass graft		C					
35651	Artery bypass graft		C					
35654	Artery bypass graft		C					
35656	Artery bypass graft		C					
35661	Artery bypass graft		C					
35663	Artery bypass graft		C					
35665	Artery bypass graft		C					
35666	Artery bypass graft		C					
35671	Artery bypass graft		C					
35681	Composite bypass graft		C					
35682	Composite bypass graft		C					
35683	Composite bypass graft		C					
35685	Bypass graft patency/patch		T	0093	36.4868	$2,513.06	.	$502.62
35686	Bypass graft/av fist patency		T	0093	36.4868	$2,513.06	.	$502.62
35691	Arterial transposition		C					
35693	Arterial transposition		C					
35694	Arterial transposition		C					
35695	Arterial transposition		C					
35697	Reimplant artery each		C					
35700	Reoperation bypass graft		C					
35701	Exploration carotid artery		C					
35721	Exploration femoral artery		C					
35741	Exploration popliteal artery		C					
35761	Exploration of artery/vein		T	0093	36.4868	$2,513.06	.	$502.62
35800	Explore neck vessels		C					
35820	Explore chest vessels		C					
35840	Explore abdominal vessels		C					
35860	Explore limb vessels		T	0093	36.4868	$2,513.06	.	$502.62
35870	Repair vessel graft defect		C					
35875	Removal of clot in graft		T	0088	41.7208	$2,873.56	$655.22	$574.72
35876	Removal of clot in graft		T	0088	41.7208	$2,873.56	$655.22	$574.72
35879	Revise graft w/vein		T	0088	41.7208	$2,873.56	$655.22	$574.72
35881	Revise graft w/vein		T	0088	41.7208	$2,873.56	$655.22	$574.72
35883	Revise graft w/nonauto graft		T	0088	41.7208	$2,873.56	$655.22	$574.72
35884	Revise graft w/vein		T	0088	41.7208	$2,873.56	$655.22	$574.72
35901	Excision graft neck		C					
35903	Excision graft extremity		T	0093	36.4868	$2,513.06		$502.62
35905	Excision graft thorax		C					
35907	Excision graft abdomen		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36000	Place needle in vein		N					
36002	Pseudoaneurysm injection trt		S	0267	2.2212	$152.99	$59.84	$30.60
36005	Injection ext venography		N					
36010	Place catheter in vein		N					
36011	Place catheter in vein		N					
36012	Place catheter in vein		N					
36013	Place catheter in artery		N					
36014	Place catheter in artery		N					
36015	Place catheter in artery		N					
36100	Establish access to artery		N					
36120	Establish access to artery		N					
36140	Establish access to artery		N					
36147	Access av dial grft for eval		T	0676	2.3474	$161.68	.	$32.34
36148	Access av dial grft for proc		N					
36160	Establish access to aorta		N					
36200	Place catheter in aorta		N					
36215	Place catheter in artery		N					
36216	Place catheter in artery		N					
36217	Place catheter in artery		N					
36218	Place catheter in artery		N					
36245	Place catheter in artery		N					
36246	Place catheter in artery		N					
36247	Place catheter in artery		N					
36248	Place catheter in artery		N					
36260	Insertion of infusion pump		T	0623	30.7762	$2,119.74	.	$423.95
36261	Revision of infusion pump		T	0105	22.7342	$1,565.84	.	$313.17
36262	Removal of infusion pump		T	0105	22.7342	$1,565.84	.	$313.17
36299	Vessel injection procedure		N					
36400	Bl draw < 3 yrs fem/jugular		N					
36405	Bl draw < 3 yrs scalp vein		N					
36406	Bl draw < 3 yrs other vein		N					
36410	Non-routine bl draw > 3 yrs		N					
36415	Routine venipuncture		A					
36416	Capillary blood draw		N					
36420	Vein access cutdown < 1 yr		X	0035	0.2674	$18.42	.	$3.69
36425	Vein access cutdown > 1 yr		X	0035	0.2674	$18.42	.	$3.69
36430	Blood transfusion service		S	0110	3.3918	$233.61	.	$46.73
36440	Bl push transfuse 2 yr or <		S	0110	3.3918	$233.61	.	$46.73
36450	Bl exchange/transfuse nb		S	0110	3.3918	$233.61	.	$46.73

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36455	Bl exchange/transfuse non-nb		S	0110	3.3918	$233.61	.	$46.73
36460	Transfusion service fetal		S	0110	3.3918	$233.61	.	$46.73
36468	Injection(s) spider veins		T	0013	0.9103	$62.70	.	$12.54
36469	Injection(s) spider veins		T	0013	0.9103	$62.70	.	$12.54
36470	Injection therapy of vein		T	0013	0.9103	$62.70	.	$12.54
36471	Injection therapy of veins		T	0013	0.9103	$62.70	.	$12.54
36475	Endovenous rf 1st vein		T	0091	43.9936	$3,030.10	.	$606.02
36476	Endovenous rf vein add-on		T	0092	27.4530	$1,890.85	.	$378.17
36478	Endovenous laser 1st vein		T	0092	27.4530	$1,890.85	.	$378.17
36479	Endovenous laser vein addon		T	0092	27.4530	$1,890.85	.	$378.17
36481	Insertion of catheter vein		N					
36500	Insertion of catheter vein		N					
36510	Insertion of catheter vein		N					
36511	Apheresis wbc		S	0111	12.3872	$853.18	$198.40	$170.64
36512	Apheresis rbc		S	0111	12.3872	$853.18	$198.40	$170.64
36513	Apheresis platelets		S	0111	12.3872	$853.18	$198.40	$170.64
36514	Apheresis plasma		S	0111	12.3872	$853.18	$198.40	$170.64
36515	Apheresis adsorp/reinfuse		S	0112	31.4526	$2,166.33	.	$433.27
36516	Apheresis selective		S	0112	31.4526	$2,166.33	.	$433.27
36522	Photopheresis		S	0112	31.4526	$2,166.33	.	$433.27
36555	Insert non-tunnel cv cath		T	0621	11.3694	$783.08	.	$156.62
36556	Insert non-tunnel cv cath		T	0621	11.3694	$783.08	.	$156.62
36557	Insert tunneled cv cath		T	0622	25.6718	$1,768.17	.	$353.64
36558	Insert tunneled cv cath		T	0622	25.6718	$1,768.17	.	$353.64
36560	Insert tunneled cv cath		T	0623	30.7762	$2,119.74	.	$423.95
36561	Insert tunneled cv cath		T	0623	30.7762	$2,119.74	.	$423.95
36563	Insert tunneled cv cath		T	0623	30.7762	$2,119.74	.	$423.95
36565	Insert tunneled cv cath		T	0623	30.7762	$2,119.74	.	$423.95
36566	Insert tunneled cv cath		T	0623	30.7762	$2,119.74	.	$423.95
36568	Insert picc cath		T	0621	11.3694	$783.08	.	$156.62
36569	Insert picc cath		T	0621	11.3694	$783.08	.	$156.62
36570	Insert picvad cath		T	0622	25.6718	$1,768.17	.	$353.64
36571	Insert picvad cath		T	0622	25.6718	$1,768.17	.	$353.64
36575	Repair tunneled cv cath		T	0121	6.3298	$435.97	.	$87.20
36576	Repair tunneled cv cath		T	0621	11.3694	$783.08	.	$156.62
36578	Replace tunneled cv cath		T	0622	25.6718	$1,768.17	.	$353.64
36580	Replace cvad cath		T	0621	11.3694	$783.08	.	$156.62
36581	Replace tunneled cv cath		T	0622	25.6718	$1,768.17	.	$353.64
36582	Replace tunneled cv cath		T	0623	30.7762	$2,119.74	.	$423.95

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36583	Replace tunneled cv cath		T	0623	30.7762	$2,119.74	.	$423.95
36584	Replace picc cath		T	0621	11.3694	$783.08	.	$156.62
36585	Replace picvad cath		T	0622	25.6718	$1,768.17	.	$353.64
36589	Removal tunneled cv cath		T	0121	6.3298	$435.97	.	$87.20
36590	Removal tunneled cv cath		T	0621	11.3694	$783.08	.	$156.62
36591	Draw blood off venous device		Q1	0624	0.6328	$43.58	$12.65	$8.72
36592	Collect blood from picc		Q1	0624	0.6328	$43.58	$12.65	$8.72
36593	Declot vascular device		T	0676	2.3474	$161.68	.	$32.34
36595	Mech remov tunneled cv cath		T	0622	25.6718	$1,768.17	.	$353.64
36596	Mech remov tunneled cv cath		T	0621	11.3694	$783.08	.	$156.62
36597	Reposition venous catheter		T	0621	11.3694	$783.08	.	$156.62
36598	Inj w/fluor eval cv device		T	0676	2.3474	$161.68	.	$32.34
36600	Withdrawal of arterial blood	CH	Q3	0035	0.2674	$18.42	.	$3.69
36620	Insertion catheter artery		N					
36625	Insertion catheter artery		N					
36640	Insertion catheter artery		T	0623	30.7762	$2,119.74	.	$423.95
36660	Insertion catheter artery		C					
36680	Insert needle bone cavity		T	0002	1.5703	$108.16	.	$21.64
36800	Insertion of cannula		T	0115	35.0863	$2,416.60	.	$483.32
36810	Insertion of cannula		T	0115	35.0863	$2,416.60	.	$483.32
36815	Insertion of cannula		T	0115	35.0863	$2,416.60	.	$483.32
36818	Av fuse uppr arm cephalic		T	0088	41.7208	$2,873.56	$655.22	$574.72
36819	Av fuse uppr arm basilic		T	0088	41.7208	$2,873.56	$655.22	$574.72
36820	Av fusion/forearm vein		T	0088	41.7208	$2,873.56	$655.22	$574.72
36821	Av fusion direct any site		T	0088	41.7208	$2,873.56	$655.22	$574.72
36822	Insertion of cannula(s)		C					
36823	Insertion of cannula(s)		C					
36825	Artery-vein autograft		T	0088	41.7208	$2,873.56	$655.22	$574.72
36830	Artery-vein nonautograft		T	0088	41.7208	$2,873.56	$655.22	$574.72
36831	Open thrombect av fistula		T	0088	41.7208	$2,873.56	$655.22	$574.72
36832	Av fistula revision open		T	0088	41.7208	$2,873.56	$655.22	$574.72
36833	Av fistula revision		T	0088	41.7208	$2,873.56	$655.22	$574.72
36835	Artery to vein shunt		T	0115	35.0863	$2,416.60	.	$483.32
36838	Dist revas ligation hemo		T	0088	41.7208	$2,873.56	$655.22	$574.72
36860	External cannula declotting		T	0676	2.3474	$161.68	.	$32.34
36861	Cannula declotting		T	0115	35.0863	$2,416.60	.	$483.32
36870	Percut thrombect av fistula		T	0653	45.1001	$3,106.31	.	$621.27
37140	Revision of circulation		C					
37145	Revision of circulation		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
37160	Revision of circulation		C					
37180	Revision of circulation		C					
37181	Splice spleen/kidney veins		C					
37182	Insert hepatic shunt (tips)		C					
37183	Remove hepatic shunt (tips)		T	0229	116.5174	$8,025.25	.	$1,605.05
37184	Prim art mech thrombectomy		T	0088	41.7208	$2,873.56	$655.22	$574.72
37185	Prim art m-thrombect add-on		T	0088	41.7208	$2,873.56	$655.22	$574.72
37186	Sec art m-thrombect add-on		T	0088	41.7208	$2,873.56	$655.22	$574.72
37187	Venous mech thrombectomy		T	0088	41.7208	$2,873.56	$655.22	$574.72
37188	Venous m-thrombectomy add-on		T	0088	41.7208	$2,873.56	$655.22	$574.72
37195	Thrombolytic therapy stroke		T	0676	2.3474	$161.68	.	$32.34
37200	Transcatheter biopsy		T	0623	30.7762	$2,119.74	.	$423.95
37201	Transcatheter therapy infuse		T	0103	19.1361	$1,318.02	.	$263.61
37202	Transcatheter therapy infuse		T	0103	19.1361	$1,318.02	.	$263.61
37203	Transcatheter retrieval		T	0623	30.7762	$2,119.74	.	$423.95
37204	Transcatheter occlusion		T	0082	92.7252	$6,386.54	.	$1,277.31
37205	Transcath iv stent percut	NI	T	0229	116.5174	$8,025.25	.	$1,605.05
37206	Transcath iv stent/perc addl	NI	T	0229	116.5174	$8,025.25	.	$1,605.05
37207	Transcath iv stent open		T	0229	116.5174	$8,025.25	.	$1,605.05
37208	Transcath iv stent/open addl		T	0229	116.5174	$8,025.25	.	$1,605.05
37209	Change iv cath at thromb tx		T	0623	30.7762	$2,119.74	.	$423.95
37210	Embolization uterine fibroid		T	0229	116.5174	$8,025.25	.	$1,605.05
37215	Transcath stent cca w/eps		C					
37216	Transcath stent cca w/o eps		E					
37220	Iliac revasc	NI	T	0083	54.8838	$3,780.18	.	$756.04
37221	Iliac revasc w/stent	NI	T	0083	54.8838	$3,780.18	.	$756.04
37222	Iliac revasc add-on	NI	T	0083	54.8838	$3,780.18	.	$756.04
37223	Iliac revasc w/stent add-on	NI	T	0083	54.8838	$3,780.18	.	$756.04
37224	Fem/popl revas w/tla	NI	T	0083	54.8838	$3,780.18	.	$756.04
37225	Fem/popl revas w/ather	NI	T	0229	116.5174	$8,025.25	.	$1,605.05
37226	Fem/popl revasc w/stent	NI	T	0229	116.5174	$8,025.25	.	$1,605.05
37227	Fem/popl revasc stnt & ather	NI	T	0319	201.7932	$13,898.71	$5,559.48	$2,779.75
37228	Tib/per revasc w/tla	NI	T	0083	54.8838	$3,780.18	.	$756.04
37229	Tib/per revasc w/ather	NI	T	0229	116.5174	$8,025.25	.	$1,605.05
37230	Tib/per revasc w/stent	NI	T	0229	116.5174	$8,025.25	.	$1,605.05
37231	Tib/per revasc stent & ather	NI	T	0319	201.7932	$13,898.71	$5,559.48	$2,779.75
37232	Tib/per revasc add-on	NI	T	0083	54.8838	$3,780.18	.	$756.04
37233	Tibper revasc w/ather add-on	NI	T	0229	116.5174	$8,025.25	.	$1,605.05

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
37234	Revsc opn/prq tib/pero stent	NI	T	0083	54.8838	$3,780.18	.	$756.04
37235	Tib/per revasc stnt & ather	NI	T	0083	54.8838	$3,780.18	.	$756.04
37250	Iv us first vessel add-on		N					
37251	Iv us each add vessel add-on		N					
37500	Endoscopy ligate perf veins		T	0091	43.9936	$3,030.10	.	$606.02
37501	Vascular endoscopy procedure		T	0092	27.4530	$1,890.85	.	$378.17
37565	Ligation of neck vein		T	0093	36.4868	$2,513.06	.	$502.62
37600	Ligation of neck artery		T	0093	36.4868	$2,513.06	.	$502.62
37605	Ligation of neck artery		T	0091	43.9936	$3,030.10	.	$606.02
37606	Ligation of neck artery		T	0092	27.4530	$1,890.85	.	$378.17
37607	Ligation of a-v fistula		T	0092	27.4530	$1,890.85	.	$378.17
37609	Temporal artery procedure		T	0021	18.0784	$1,245.17	.	$249.04
37615	Ligation of neck artery		T	0092	27.4530	$1,890.85	.	$378.17
37616	Ligation of chest artery		C					
37617	Ligation of abdomen artery		C					
37618	Ligation of extremity artery		C					
37620	Revision of major vein		T	0091	43.9936	$3,030.10	.	$606.02
37650	Revision of major vein		T	0092	27.4530	$1,890.85	.	$378.17
37660	Revision of major vein		C					
37700	Revise leg vein		T	0092	27.4530	$1,890.85	.	$378.17
37718	Ligate/strip short leg vein		T	0092	27.4530	$1,890.85	.	$378.17
37722	Ligate/strip long leg vein		T	0091	43.9936	$3,030.10	.	$606.02
37735	Removal of leg veins/lesion		T	0091	43.9936	$3,030.10	.	$606.02
37760	Ligate leg veins radical		T	0092	27.4530	$1,890.85	.	$378.17
37761	Ligate leg veins open		T	0092	27.4530	$1,890.85	.	$378.17
37765	Stab phleb veins xtr 10-20		T	0092	27.4530	$1,890.85	.	$378.17
37766	Phleb veins - extrem 20+		T	0092	27.4530	$1,890.85	.	$378.17
37780	Revision of leg vein		T	0092	27.4530	$1,890.85	.	$378.17
37785	Ligate/divide/excise vein		T	0092	27.4530	$1,890.85	.	$378.17
37788	Revascularization penis		C					
37790	Penile venous occlusion		T	0181	35.9464	$2,475.84	$620.84	$495.17
37799	Vascular surgery procedure		X	0624	0.6328	$43.58	$12.65	$8.72
38100	Removal of spleen total		C					
38101	Removal of spleen partial		C					
38102	Removal of spleen total		C					
38115	Repair of ruptured spleen		C					
38120	Laparoscopy splenectomy		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
38129	Laparoscope proc spleen		T	0130	38.6514	$2,662.15	$659.53	$532.43
38200	Injection for spleen x-ray		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
38204	Bl donor search management		N					
38205	Harvest allogenic stem cells		B					
38206	Harvest auto stem cells		S	0111	12.3872	$853.18	$198.40	$170.64
38207	Cryopreserve stem cells		S	0110	3.3918	$233.61	.	$46.73
38208	Thaw preserved stem cells		S	0110	3.3918	$233.61	.	$46.73
38209	Wash harvest stem cells		S	0110	3.3918	$233.61	.	$46.73
38210	T-cell depletion of harvest		S	0393	6.0745	$418.39	.	$83.68
38211	Tumor cell deplete of harvst		S	0393	6.0745	$418.39	.	$83.68
38212	Rbc depletion of harvest		S	0393	6.0745	$418.39	.	$83.68
38213	Platelet deplete of harvest		S	0393	6.0745	$418.39	.	$83.68
38214	Volume deplete of harvest		S	0393	6.0745	$418.39	.	$83.68
38215	Harvest stem cell concentrte		S	0393	6.0745	$418.39	.	$83.68
38220	Bone marrow aspiration		T	0003	3.7390	$257.53	.	$51.51
38221	Bone marrow biopsy		T	0003	3.7390	$257.53	.	$51.51
38230	Bone marrow collection		S	0112	31.4526	$2,166.33	.	$433.27
38240	Bone marrow/stem transplant		S	0112	31.4526	$2,166.33	.	$433.27
38241	Bone marrow/stem transplant		S	0112	31.4526	$2,166.33	.	$433.27
38242	Lymphocyte infuse transplant		S	0111	12.3872	$853.18	$198.40	$170.64
38300	Drainage lymph node lesion		T	0007	13.0129	$896.28	.	$179.26
38305	Drainage lymph node lesion		T	0008	20.1996	$1,391.27	.	$278.26
38308	Incision of lymph channels		T	0113	25.0607	$1,726.08	.	$345.22
38380	Thoracic duct procedure		C					
38381	Thoracic duct procedure		C					
38382	Thoracic duct procedure		C					
38500	Biopsy/removal lymph nodes		T	0113	25.0607	$1,726.08	.	$345.22
38505	Needle biopsy lymph nodes		T	0005	8.1362	$560.39	.	$112.08
38510	Biopsy/removal lymph nodes		T	0113	25.0607	$1,726.08	.	$345.22
38520	Biopsy/removal lymph nodes		T	0113	25.0607	$1,726.08	.	$345.22
38525	Biopsy/removal lymph nodes		T	0113	25.0607	$1,726.08	.	$345.22
38530	Biopsy/removal lymph nodes		T	0113	25.0607	$1,726.08	.	$345.22
38542	Explore deep node(s) neck		T	0114	50.7814	$3,497.62	.	$699.53
38550	Removal neck/armpit lesion		T	0113	25.0607	$1,726.08	.	$345.22
38555	Removal neck/armpit lesion		T	0113	25.0607	$1,726.08	.	$345.22
38562	Removal pelvic lymph nodes		C					
38564	Removal abdomen lymph nodes		C					
38570	Laparoscopy lymph node biop		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
38571	Laparoscopy lymphadenectomy		T	0132	71.0980	$4,896.95	$1,236.99	$979.39

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
38572	Laparoscopy lymphadenectomy		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
38589	Laparoscope proc lymphatic		T	0130	38.6514	$2,662.15	$659.53	$532.43
38700	Removal of lymph nodes neck		T	0113	25.0607	$1,726.08	.	$345.22
38720	Removal of lymph nodes neck		T	0113	25.0607	$1,726.08	.	$345.22
38724	Removal of lymph nodes neck		C					
38740	Remove armpit lymph nodes		T	0114	50.7814	$3,497.62	.	$699.53
38745	Remove armpit lymph nodes		T	0114	50.7814	$3,497.62	.	$699.53
38746	Remove thoracic lymph nodes		C					
38747	Remove abdominal lymph nodes		C					
38760	Remove groin lymph nodes		T	0113	25.0607	$1,726.08	.	$345.22
38765	Remove groin lymph nodes		C					
38770	Remove pelvis lymph nodes		C					
38780	Remove abdomen lymph nodes		C					
38790	Inject for lymphatic x-ray		N					
38792	Identify sentinel node		Q1	0392	2.5248	$173.90	$42.39	$34.78
38794	Access thoracic lymph duct		N					
38900	Io map of sent lymph node	NI	N					
38999	Blood/lymph system procedure		S	0110	3.3918	$233.61	.	$46.73
39000	Exploration of chest		C					
39010	Exploration of chest		C					
39200	Removal chest lesion		C					
39220	Removal chest lesion		C					
39400	Visualization of chest		T	0069	34.8422	$2,399.79	$591.64	$479.96
39499	Chest procedure		C					
39501	Repair diaphragm laceration		C					
39502	Repair paraesophageal hernia	CH	D					
39503	Repair of diaphragm hernia		C					
39520	Repair of diaphragm hernia	CH	D					
39530	Repair of diaphragm hernia	CH	D					
39531	Repair of diaphragm hernia	CH	D					
39540	Repair of diaphragm hernia		C					
39541	Repair of diaphragm hernia		C					
39545	Revision of diaphragm		C					
39560	Resect diaphragm simple		C					
39561	Resect diaphragm complex		C					
39599	Diaphragm surgery procedure		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
40490	Biopsy of lip		T	0251	3.5538	$244.77	.	$48.96
40500	Partial excision of lip		T	0253	17.3388	$1,194.23	$282.29	$238.85
40510	Partial excision of lip		T	0254	25.6472	$1,766.48	.	$353.30
40520	Partial excision of lip		T	0253	17.3388	$1,194.23	$282.29	$238.85
40525	Reconstruct lip with flap		T	0254	25.6472	$1,766.48	.	$353.30
40527	Reconstruct lip with flap		T	0254	25.6472	$1,766.48	.	$353.30
40530	Partial removal of lip		T	0254	25.6472	$1,766.48	.	$353.30
40650	Repair lip		T	0252	7.9194	$545.46	$109.16	$109.10
40652	Repair lip		T	0252	7.9194	$545.46	$109.16	$109.10
40654	Repair lip		T	0252	7.9194	$545.46	$109.16	$109.10
40700	Repair cleft lip/nasal		T	0256	44.6899	$3,078.06	.	$615.62
40701	Repair cleft lip/nasal		T	0256	44.6899	$3,078.06	.	$615.62
40702	Repair cleft lip/nasal		T	0256	44.6899	$3,078.06	.	$615.62
40720	Repair cleft lip/nasal		T	0256	44.6899	$3,078.06	.	$615.62
40761	Repair cleft lip/nasal		T	0256	44.6899	$3,078.06	.	$615.62
40799	Lip surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61
40800	Drainage of mouth lesion		T	0006	1.4906	$102.67	.	$20.54
40801	Drainage of mouth lesion		T	0252	7.9194	$545.46	$109.16	$109.10
40804	Removal foreign body mouth		X	0340	0.6712	$46.23	.	$9.25
40805	Removal foreign body mouth		T	0252	7.9194	$545.46	$109.16	$109.10
40806	Incision of lip fold		T	0251	3.5538	$244.77	.	$48.96
40808	Biopsy of mouth lesion		T	0251	3.5538	$244.77	.	$48.96
40810	Excision of mouth lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
40812	Excise/repair mouth lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
40814	Excise/repair mouth lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
40816	Excision of mouth lesion		T	0254	25.6472	$1,766.48	.	$353.30
40818	Excise oral mucosa for graft		T	0251	3.5538	$244.77	.	$48.96
40819	Excise lip or cheek fold		T	0252	7.9194	$545.46	$109.16	$109.10
40820	Treatment of mouth lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
40830	Repair mouth laceration		T	0251	3.5538	$244.77	.	$48.96
40831	Repair mouth laceration		T	0252	7.9194	$545.46	$109.16	$109.10
40840	Reconstruction of mouth		T	0254	25.6472	$1,766.48	.	$353.30
40842	Reconstruction of mouth		T	0254	25.6472	$1,766.48	.	$353.30
40843	Reconstruction of mouth		T	0254	25.6472	$1,766.48	.	$353.30
40844	Reconstruction of mouth		T	0256	44.6899	$3,078.06	.	$615.62
40845	Reconstruction of mouth		T	0256	44.6899	$3,078.06	.	$615.62
40899	Mouth surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61
41000	Drainage of mouth lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
41005	Drainage of mouth lesion		T	0251	3.5538	$244.77	.	$48.96

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
41006	Drainage of mouth lesion		T	0254	25.6472	$1,766.48	.	$353.30
41007	Drainage of mouth lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
41008	Drainage of mouth lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
41009	Drainage of mouth lesion		T	0251	3.5538	$244.77	.	$48.96
41010	Incision of tongue fold		T	0252	7.9194	$545.46	$109.16	$109.10
41015	Drainage of mouth lesion		T	0251	3.5538	$244.77	.	$48.96
41016	Drainage of mouth lesion		T	0252	7.9194	$545.46	$109.16	$109.10
41017	Drainage of mouth lesion		T	0252	7.9194	$545.46	$109.16	$109.10
41018	Drainage of mouth lesion		T	0252	7.9194	$545.46	$109.16	$109.10
41019	Place needles h&n for rt		T	0254	25.6472	$1,766.48	.	$353.30
41100	Biopsy of tongue		T	0252	7.9194	$545.46	$109.16	$109.10
41105	Biopsy of tongue		T	0253	17.3388	$1,194.23	$282.29	$238.85
41108	Biopsy of floor of mouth		T	0019	5.0887	$350.49	.	$70.10
41110	Excision of tongue lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
41112	Excision of tongue lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
41113	Excision of tongue lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
41114	Excision of tongue lesion		T	0254	25.6472	$1,766.48	.	$353.30
41115	Excision of tongue fold		T	0252	7.9194	$545.46	$109.16	$109.10
41116	Excision of mouth lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
41120	Partial removal of tongue		T	0254	25.6472	$1,766.48	.	$353.30
41130	Partial removal of tongue		C					
41135	Tongue and neck surgery		C					
41140	Removal of tongue		C					
41145	Tongue removal neck surgery		C					
41150	Tongue mouth jaw surgery		C					
41153	Tongue mouth neck surgery		C					
41155	Tongue jaw & neck surgery		C					
41250	Repair tongue laceration		T	0250	1.1331	$78.04	$25.10	$15.61
41251	Repair tongue laceration		T	0251	3.5538	$244.77	.	$48.96
41252	Repair tongue laceration		T	0252	7.9194	$545.46	$109.16	$109.10
41500	Fixation of tongue		T	0254	25.6472	$1,766.48	.	$353.30
41510	Tongue to lip surgery		T	0253	17.3388	$1,194.23	$282.29	$238.85
41512	Tongue suspension		T	0252	7.9194	$545.46	$109.16	$109.10
41520	Reconstruction tongue fold		T	0252	7.9194	$545.46	$109.16	$109.10
41530	Tongue base vol reduction		T	0254	25.6472	$1,766.48	.	$353.30
41599	Tongue and mouth surgery		T	0250	1.1331	$78.04	$25.10	$15.61
41800	Drainage of gum lesion		T	0006	1.4906	$102.67	.	$20.54
41805	Removal foreign body gum		T	0254	25.6472	$1,766.48	.	$353.30
41806	Removal foreign body jawbone		T	0253	17.3388	$1,194.23	$282.29	$238.85

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
41820	Excision gum each quadrant		T	0252	7.9194	$545.46	$109.16	$109.10
41821	Excision of gum flap		T	0252	7.9194	$545.46	$109.16	$109.10
41822	Excision of gum lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
41823	Excision of gum lesion		T	0254	25.6472	$1,766.48	.	$353.30
41825	Excision of gum lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
41826	Excision of gum lesion		T	0254	25.6472	$1,766.48	.	$353.30
41827	Excision of gum lesion		T	0254	25.6472	$1,766.48	.	$353.30
41828	Excision of gum lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
41830	Removal of gum tissue		T	0253	17.3388	$1,194.23	$282.29	$238.85
41850	Treatment of gum lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
41870	Gum graft		T	0254	25.6472	$1,766.48	.	$353.30
41872	Repair gum		T	0253	17.3388	$1,194.23	$282.29	$238.85
41874	Repair tooth socket		T	0254	25.6472	$1,766.48	.	$353.30
41899	Dental surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61
42000	Drainage mouth roof lesion		T	0251	3.5538	$244.77	.	$48.96
42100	Biopsy roof of mouth		T	0252	7.9194	$545.46	$109.16	$109.10
42104	Excision lesion mouth roof		T	0253	17.3388	$1,194.23	$282.29	$238.85
42106	Excision lesion mouth roof		T	0253	17.3388	$1,194.23	$282.29	$238.85
42107	Excision lesion mouth roof		T	0254	25.6472	$1,766.48	.	$353.30
42120	Remove palate/lesion		T	0256	44.6899	$3,078.06	.	$615.62
42140	Excision of uvula		T	0252	7.9194	$545.46	$109.16	$109.10
42145	Repair palate pharynx/uvula		T	0254	25.6472	$1,766.48	.	$353.30
42160	Treatment mouth roof lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
42180	Repair palate		T	0251	3.5538	$244.77	.	$48.96
42182	Repair palate		T	0256	44.6899	$3,078.06	.	$615.62
42200	Reconstruct cleft palate		T	0256	44.6899	$3,078.06	.	$615.62
42205	Reconstruct cleft palate		T	0256	44.6899	$3,078.06	.	$615.62
42210	Reconstruct cleft palate		T	0256	44.6899	$3,078.06	.	$615.62
42215	Reconstruct cleft palate		T	0256	44.6899	$3,078.06	.	$615.62
42220	Reconstruct cleft palate		T	0256	44.6899	$3,078.06	.	$615.62
42225	Reconstruct cleft palate		T	0256	44.6899	$3,078.06	.	$615.62
42226	Lengthening of palate		T	0256	44.6899	$3,078.06	.	$615.62
42227	Lengthening of palate		T	0256	44.6899	$3,078.06	.	$615.62
42235	Repair palate		T	0253	17.3388	$1,194.23	$282.29	$238.85
42260	Repair nose to lip fistula		T	0254	25.6472	$1,766.48	.	$353.30
42280	Preparation palate mold		T	0251	3.5538	$244.77	.	$48.96
42281	Insertion palate prosthesis		T	0253	17.3388	$1,194.23	$282.29	$238.85
42299	Palate/uvula surgery		T	0250	1.1331	$78.04	$25.10	$15.61
42300	Drainage of salivary gland		T	0253	17.3388	$1,194.23	$282.29	$238.85

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42305	Drainage of salivary gland		T	0253	17.3388	$1,194.23	$282.29	$238.85
42310	Drainage of salivary gland		T	0251	3.5538	$244.77	.	$48.96
42320	Drainage of salivary gland		T	0251	3.5538	$244.77	.	$48.96
42330	Removal of salivary stone		T	0253	17.3388	$1,194.23	$282.29	$238.85
42335	Removal of salivary stone		T	0253	17.3388	$1,194.23	$282.29	$238.85
42340	Removal of salivary stone		T	0253	17.3388	$1,194.23	$282.29	$238.85
42400	Biopsy of salivary gland		T	0005	8.1362	$560.39	.	$112.08
42405	Biopsy of salivary gland		T	0254	25.6472	$1,766.48	.	$353.30
42408	Excision of salivary cyst		T	0253	17.3388	$1,194.23	$282.29	$238.85
42409	Drainage of salivary cyst		T	0253	17.3388	$1,194.23	$282.29	$238.85
42410	Excise parotid gland/lesion		T	0256	44.6899	$3,078.06	.	$615.62
42415	Excise parotid gland/lesion		T	0256	44.6899	$3,078.06	.	$615.62
42420	Excise parotid gland/lesion		T	0256	44.6899	$3,078.06	.	$615.62
42425	Excise parotid gland/lesion		T	0256	44.6899	$3,078.06	.	$615.62
42426	Excise parotid gland/lesion		C					
42440	Excise submaxillary gland		T	0256	44.6899	$3,078.06	.	$615.62
42450	Excise sublingual gland		T	0254	25.6472	$1,766.48	.	$353.30
42500	Repair salivary duct		T	0254	25.6472	$1,766.48	.	$353.30
42505	Repair salivary duct		T	0256	44.6899	$3,078.06	.	$615.62
42507	Parotid duct diversion		T	0256	44.6899	$3,078.06	.	$615.62
42508	Parotid duct diversion		T	0256	44.6899	$3,078.06	.	$615.62
42509	Parotid duct diversion		T	0256	44.6899	$3,078.06	.	$615.62
42510	Parotid duct diversion		T	0256	44.6899	$3,078.06	.	$615.62
42550	Injection for salivary x-ray		N					
42600	Closure of salivary fistula		T	0253	17.3388	$1,194.23	$282.29	$238.85
42650	Dilation of salivary duct		T	0252	7.9194	$545.46	$109.16	$109.10
42660	Dilation of salivary duct		T	0251	3.5538	$244.77	.	$48.96
42665	Ligation of salivary duct		T	0254	25.6472	$1,766.48	.	$353.30
42699	Salivary surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61
42700	Drainage of tonsil abscess		T	0251	3.5538	$244.77	.	$48.96
42720	Drainage of throat abscess		T	0253	17.3388	$1,194.23	$282.29	$238.85
42725	Drainage of throat abscess		T	0256	44.6899	$3,078.06	.	$615.62
42800	Biopsy of throat	CH	T	0252	7.9194	$545.46	$109.16	$109.10
42802	Biopsy of throat		T	0253	17.3388	$1,194.23	$282.29	$238.85
42804	Biopsy of upper nose/throat		T	0253	17.3388	$1,194.23	$282.29	$238.85
42806	Biopsy of upper nose/throat		T	0254	25.6472	$1,766.48	.	$353.30
42808	Excise pharynx lesion		T	0254	25.6472	$1,766.48	.	$353.30
42809	Remove pharynx foreign body		X	0340	0.6712	$46.23	.	$9.25
42810	Excision of neck cyst		T	0254	25.6472	$1,766.48	.	$353.30

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42815	Excision of neck cyst		T	0256	44.6899	$3,078.06	.	$615.62
42820	Remove tonsils and adenoids		T	0254	25.6472	$1,766.48	.	$353.30
42821	Remove tonsils and adenoids		T	0254	25.6472	$1,766.48	.	$353.30
42825	Removal of tonsils		T	0254	25.6472	$1,766.48	.	$353.30
42826	Removal of tonsils		T	0254	25.6472	$1,766.48	.	$353.30
42830	Removal of adenoids		T	0254	25.6472	$1,766.48	.	$353.30
42831	Removal of adenoids		T	0254	25.6472	$1,766.48	.	$353.30
42835	Removal of adenoids		T	0254	25.6472	$1,766.48	.	$353.30
42836	Removal of adenoids		T	0254	25.6472	$1,766.48	.	$353.30
42842	Extensive surgery of throat		T	0254	25.6472	$1,766.48	.	$353.30
42844	Extensive surgery of throat		T	0256	44.6899	$3,078.06	.	$615.62
42845	Extensive surgery of throat		C					
42860	Excision of tonsil tags		T	0254	25.6472	$1,766.48	.	$353.30
42870	Excision of lingual tonsil		T	0254	25.6472	$1,766.48	.	$353.30
42890	Partial removal of pharynx		T	0256	44.6899	$3,078.06	.	$615.62
42892	Revision of pharyngeal walls		T	0256	44.6899	$3,078.06	.	$615.62
42894	Revision of pharyngeal walls		C					
42900	Repair throat wound		T	0252	7.9194	$545.46	$109.16	$109.10
42950	Reconstruction of throat		T	0254	25.6472	$1,766.48	.	$353.30
42953	Repair throat esophagus		C					
42955	Surgical opening of throat		T	0254	25.6472	$1,766.48	.	$353.30
42960	Control throat bleeding		T	0250	1.1331	$78.04	$25.10	$15.61
42961	Control throat bleeding		C					
42962	Control throat bleeding		T	0256	44.6899	$3,078.06	.	$615.62
42970	Control nose/throat bleeding		T	0250	1.1331	$78.04	$25.10	$15.61
42971	Control nose/throat bleeding		C					
42972	Control nose/throat bleeding		T	0253	17.3388	$1,194.23	$282.29	$238.85
42999	Throat surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61
43020	Incision of esophagus		T	0252	7.9194	$545.46	$109.16	$109.10
43030	Throat muscle surgery		T	0253	17.3388	$1,194.23	$282.29	$238.85
43045	Incision of esophagus		C					
43100	Excision of esophagus lesion		C					
43101	Excision of esophagus lesion		C					
43107	Removal of esophagus		C					
43108	Removal of esophagus		C					
43112	Removal of esophagus		C					
43113	Removal of esophagus		C					
43116	Partial removal of esophagus		C					
43117	Partial removal of esophagus		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43118	Partial removal of esophagus		C					
43121	Partial removal of esophagus		C					
43122	Partial removal of esophagus		C					
43123	Partial removal of esophagus		C					
43124	Removal of esophagus		C					
43130	Removal of esophagus pouch		T	0256	44.6899	$3,078.06	.	$615.62
43135	Removal of esophagus pouch		C					
43200	Esophagus endoscopy		T	0141	8.8816	$611.73	$143.38	$122.35
43201	Esoph scope w/submucous inj		T	0141	8.8816	$611.73	$143.38	$122.35
43202	Esophagus endoscopy biopsy		T	0141	8.8816	$611.73	$143.38	$122.35
43204	Esoph scope w/sclerosis inj		T	0141	8.8816	$611.73	$143.38	$122.35
43205	Esophagus endoscopy/ligation		T	0141	8.8816	$611.73	$143.38	$122.35
43215	Esophagus endoscopy		T	0141	8.8816	$611.73	$143.38	$122.35
43216	Esophagus endoscopy/lesion	CH	T	0422	16.6785	$1,148.75	$280.07	$229.75
43217	Esophagus endoscopy		T	0141	8.8816	$611.73	$143.38	$122.35
43219	Esophagus endoscopy		T	0384	27.8099	$1,915.43	.	$383.09
43220	Esoph endoscopy dilation		T	0141	8.8816	$611.73	$143.38	$122.35
43226	Esoph endoscopy dilation		T	0141	8.8816	$611.73	$143.38	$122.35
43227	Esoph endoscopy repair		T	0141	8.8816	$611.73	$143.38	$122.35
43228	Esoph endoscopy ablation		T	0422	16.6785	$1,148.75	$280.07	$229.75
43231	Esoph endoscopy w/us exam		T	0141	8.8816	$611.73	$143.38	$122.35
43232	Esoph endoscopy w/us fn bx		T	0141	8.8816	$611.73	$143.38	$122.35
43234	Upper gi endoscopy exam		T	0141	8.8816	$611.73	$143.38	$122.35
43235	Uppr gi endoscopy diagnosis		T	0141	8.8816	$611.73	$143.38	$122.35
43236	Uppr gi scope w/submuc inj		T	0141	8.8816	$611.73	$143.38	$122.35
43237	Endoscopic us exam esoph		T	0141	8.8816	$611.73	$143.38	$122.35
43238	Uppr gi endoscopy w/us fn bx		T	0141	8.8816	$611.73	$143.38	$122.35
43239	Upper gi endoscopy biopsy		T	0141	8.8816	$611.73	$143.38	$122.35
43240	Esoph endoscope w/drain cyst		T	0141	8.8816	$611.73	$143.38	$122.35
43241	Upper GI endoscopy with tube		T	0141	8.8816	$611.73	$143.38	$122.35
43242	Uppr gi endoscopy w/us fn bx	CH	T	0422	16.6785	$1,148.75	$280.07	$229.75
43243	Upper gi endoscopy & inject		T	0141	8.8816	$611.73	$143.38	$122.35
43244	Upper GI endoscopy/ligation		T	0141	8.8816	$611.73	$143.38	$122.35
43245	Uppr gi scope dilate strictr		T	0141	8.8816	$611.73	$143.38	$122.35
43246	Place gastrostomy tube		T	0141	8.8816	$611.73	$143.38	$122.35
43247	Operative upper GI endoscopy		T	0141	8.8816	$611.73	$143.38	$122.35
43248	Uppr gi endoscopy/guide wire		T	0141	8.8816	$611.73	$143.38	$122.35
43249	Esoph endoscopy dilation		T	0141	8.8816	$611.73	$143.38	$122.35
43250	Upper GI endoscopy/tumor		T	0141	8.8816	$611.73	$143.38	$122.35

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43251	Operative upper GI endoscopy		T	0141	8.8816	$611.73	$143.38	$122.35
43255	Operative upper GI endoscopy		T	0141	8.8816	$611.73	$143.38	$122.35
43256	Uppr gi endoscopy w/stent		T	0384	27.8099	$1,915.43	.	$383.09
43257	Uppr gi scope w/thrml txmnt		T	0422	16.6785	$1,148.75	$280.07	$229.75
43258	Operative upper GI endoscopy		T	0141	8.8816	$611.73	$143.38	$122.35
43259	Endoscopic ultrasound exam		T	0141	8.8816	$611.73	$143.38	$122.35
43260	Endo cholangiopancreatograph		T	0151	23.2357	$1,600.38	.	$320.08
43261	Endo cholangiopancreatograph		T	0151	23.2357	$1,600.38	.	$320.08
43262	Endo cholangiopancreatograph		T	0151	23.2357	$1,600.38	.	$320.08
43263	Endo cholangiopancreatograph		T	0151	23.2357	$1,600.38	.	$320.08
43264	Endo cholangiopancreatograph		T	0151	23.2357	$1,600.38	.	$320.08
43265	Endo cholangiopancreatograph		T	0151	23.2357	$1,600.38	.	$320.08
43267	Endo cholangiopancreatograph		T	0151	23.2357	$1,600.38	.	$320.08
43268	Endo cholangiopancreatograph		T	0384	27.8099	$1,915.43	.	$383.09
43269	Endo cholangiopancreatograph		T	0384	27.8099	$1,915.43	.	$383.09
43271	Endo cholangiopancreatograph		T	0151	23.2357	$1,600.38	.	$320.08
43272	Endo cholangiopancreatograph		T	0151	23.2357	$1,600.38	.	$320.08
43273	Endoscopic pancreatoscopy		T	0151	23.2357	$1,600.38	.	$320.08
43279	Lap myotomy heller		C					
43280	Laparoscopy fundoplasty		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
43281	Lap paraesophag hern repair		C					
43282	Lap paraesoph her rpr w/mesh		C					
43283	Lap esoph lengthening	NI	C					
43289	Laparoscope proc esoph		T	0130	38.6514	$2,662.15	$659.53	$532.43
43300	Repair of esophagus		C					
43305	Repair esophagus and fistula		C					
43310	Repair of esophagus		C					
43312	Repair esophagus and fistula		C					
43313	Esophagoplasty congenital		C					
43314	Tracheo-esophagoplasty cong		C					
43320	Fuse esophagus & stomach		C					
43324	Revise esophagus & stomach	CH	D					
43325	Revise esophagus & stomach		C					
43326	Revise esophagus & stomach	CH	D					
43327	Esoph fundoplasty lap	NI	C					
43328	Esoph fundoplasty thor	NI	C					
43330	Esophagomyotomy abdominal		C					
43331	Esophagomyotomy thoracic		C					
43332	Transab esoph hiat hern rpr	NI	C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43333	Transab esoph hiat hern rpr	NI	C					
43334	Transthor diaphrag hern rpr	NI	C					
43335	Transthor diaphrag hern rpr	NI	C					
43336	Thorabd diaphr hern repair	NI	C					
43337	Thorabd diaphr hern repair	NI	C					
43338	Esoph lengthening	NI	C					
43340	Fuse esophagus & intestine		C					
43341	Fuse esophagus & intestine		C					
43350	Surgical opening esophagus		C					
43351	Surgical opening esophagus		C					
43352	Surgical opening esophagus		C					
43360	Gastrointestinal repair		C					
43361	Gastrointestinal repair		C					
43400	Ligate esophagus veins		C					
43401	Esophagus surgery for veins		C					
43405	Ligate/staple esophagus		C					
43410	Repair esophagus wound		C					
43415	Repair esophagus wound		C					
43420	Repair esophagus opening		T	0254	25.6472	$1,766.48	.	$353.30
43425	Repair esophagus opening		C					
43450	Dilate esophagus		T	0140	6.5637	$452.08	.	$90.42
43453	Dilate esophagus		T	0140	6.5637	$452.08	.	$90.42
43456	Dilate esophagus		T	0140	6.5637	$452.08	.	$90.42
43458	Dilate esophagus		T	0141	8.8816	$611.73	$143.38	$122.35
43460	Pressure treatment esophagus		C					
43496	Free jejunum flap microvasc		C					
43499	Esophagus surgery procedure		T	0141	8.8816	$611.73	$143.38	$122.35
43500	Surgical opening of stomach		C					
43501	Surgical repair of stomach		C					
43502	Surgical repair of stomach		C					
43510	Surgical opening of stomach	CH	T	0422	16.6785	$1,148.75	$280.07	$229.75
43520	Incision of pyloric muscle		C					
43600	Biopsy of stomach	CH	D					
43605	Biopsy of stomach		C					
43610	Excision of stomach lesion		C					
43611	Excision of stomach lesion		C					
43620	Removal of stomach		C					
43621	Removal of stomach		C					
43622	Removal of stomach		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43631	Removal of stomach partial		C					
43632	Removal of stomach partial		C					
43633	Removal of stomach partial		C					
43634	Removal of stomach partial		C					
43635	Removal of stomach partial		C					
43640	Vagotomy & pylorus repair		C					
43641	Vagotomy & pylorus repair		C					
43644	Lap gastric bypass/roux-en-y		C					
43645	Lap gastr bypass incl smll i		C					
43647	Lap impl electrode antrum		S	0061	90.0429	$6,201.79	.	$1,240.36
43648	Lap revise/remv eltrd antrum		T	0130	38.6514	$2,662.15	$659.53	$532.43
43651	Laparoscopy vagus nerve		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
43652	Laparoscopy vagus nerve		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
43653	Laparoscopy gastrostomy		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
43659	Laparoscope proc stom		T	0130	38.6514	$2,662.15	$659.53	$532.43
43752	Nasal/orogastric w/stent	CH	Q3	0272	1.2123	$83.50	$30.47	$16.70
43753	Tx gastro intub w/asp	NI	X	0340	0.6712	$46.23	.	$9.25
43754	Dx gastr intub w/asp spec	NI	X	0340	0.6712	$46.23	.	$9.25
43755	Dx gastr intub w/asp specs	NI	S	0097	0.9619	$66.25	$23.79	$13.25
43756	Dx duod intub w/asp spec	NI	X	0272	1.2123	$83.50	$30.47	$16.70
43757	Dx duod intub w/asp specs	NI	X	0272	1.2123	$83.50	$30.47	$16.70
43760	Change gastrostomy tube		T	0676	2.3474	$161.68	.	$32.34
43761	Reposition gastrostomy tube		T	0141	8.8816	$611.73	$143.38	$122.35
43770	Lap place gastr adj device		C					
43771	Lap revise gastr adj device		C					
43772	Lap rmvl gastr adj device		C					
43773	Lap replace gastr adj device		C					
43774	Lap rmvl gastr adj all parts		C					
43775	Lap sleeve gastrectomy	CH	E					
43800	Reconstruction of pylorus		C					
43810	Fusion of stomach and bowel		C					
43820	Fusion of stomach and bowel		C					
43825	Fusion of stomach and bowel		C					
43830	Place gastrostomy tube		T	0422	16.6785	$1,148.75	$280.07	$229.75
43831	Place gastrostomy tube		T	0141	8.8816	$611.73	$143.38	$122.35
43832	Place gastrostomy tube		C					
43840	Repair of stomach lesion		C					
43842	V-band gastroplasty		E					
43843	Gastroplasty w/o v-band		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43845	Gastroplasty duodenal switch		C					
43846	Gastric bypass for obesity		C					
43847	Gastric bypass incl small i		C					
43848	Revision gastroplasty		C					
43850	Revise stomach-bowel fusion		C					
43855	Revise stomach-bowel fusion		C					
43860	Revise stomach-bowel fusion		C					
43865	Revise stomach-bowel fusion		C					
43870	Repair stomach opening	CH	T	0422	16.6785	$1,148.75	$280.07	$229.75
43880	Repair stomach-bowel fistula		C					
43881	Impl/redo electrd antrum		C					
43882	Revise/remove electrd antrum		C					
43886	Revise gastric port open		T	0137	22.2821	$1,534.70	.	$306.94
43887	Remove gastric port open		T	0135	4.6422	$319.74	.	$63.95
43888	Change gastric port open		T	0137	22.2821	$1,534.70	.	$306.94
43999	Stomach surgery procedure		T	0141	8.8816	$611.73	$143.38	$122.35
44005	Freeing of bowel adhesion		C					
44010	Incision of small bowel		C					
44015	Insert needle cath bowel		C					
44020	Explore small intestine		C					
44021	Decompress small bowel		C					
44025	Incision of large bowel		C					
44050	Reduce bowel obstruction		C					
44055	Correct malrotation of bowel		C					
44100	Biopsy of bowel		T	0141	8.8816	$611.73	$143.38	$122.35
44110	Excise intestine lesion(s)		C					
44111	Excision of bowel lesion(s)		C					
44120	Removal of small intestine		C					
44121	Removal of small intestine		C					
44125	Removal of small intestine		C					
44126	Enterectomy w/o taper cong		C					
44127	Enterectomy w/taper cong		C					
44128	Enterectomy cong add-on		C					
44130	Bowel to bowel fusion		C					
44132	Enterectomy cadaver donor		C					
44133	Enterectomy live donor		C					
44135	Intestine transplnt cadaver		C					
44136	Intestine transplant live		C					
44137	Remove intestinal allograft		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44139	Mobilization of colon		C					
44140	Partial removal of colon		C					
44141	Partial removal of colon		C					
44143	Partial removal of colon		C					
44144	Partial removal of colon		C					
44145	Partial removal of colon		C					
44146	Partial removal of colon		C					
44147	Partial removal of colon		C					
44150	Removal of colon		C					
44151	Removal of colon/ileostomy		C					
44155	Removal of colon/ileostomy		C					
44156	Removal of colon/ileostomy		C					
44157	Colectomy w/ileoanal anast		C					
44158	Colectomy w/neo-rectum pouch		C					
44160	Removal of colon		C					
44180	Lap enterolysis		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
44186	Lap jejunostomy		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
44187	Lap ileo/jejuno-stomy		C					
44188	Lap colostomy		C					
44202	Lap enterectomy		C					
44203	Lap resect s/intestine addl		C					
44204	Laparo partial colectomy		C					
44205	Lap colectomy part w/ileum		C					
44206	Lap part colectomy w/stoma		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
44207	L colectomy/coloproctostomy		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
44208	L colectomy/coloproctostomy		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
44210	Laparo total proctocolectomy		C					
44211	Lap colectomy w/proctectomy		C					
44212	Laparo total proctocolectomy		C					
44213	Lap mobil splenic fl add-on		T	0130	38.6514	$2,662.15	$659.53	$532.43
44227	Lap close enterostomy		C					
44238	Laparoscope proc intestine		T	0130	38.6514	$2,662.15	$659.53	$532.43
44300	Open bowel to skin		C					
44310	Ileostomy/jejunostomy		C					
44312	Revision of ileostomy		T	0137	22.2821	$1,534.70	.	$306.94
44314	Revision of ileostomy		C					
44316	Devise bowel pouch		C					
44320	Colostomy		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44322	Colostomy with biopsies		C					
44340	Revision of colostomy		T	0137	22.2821	$1,534.70	.	$306.94
44345	Revision of colostomy		C					
44346	Revision of colostomy		C					
44360	Small bowel endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
44361	Small bowel endoscopy/biopsy		T	0142	10.1857	$701.55	$152.78	$140.31
44363	Small bowel endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
44364	Small bowel endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
44365	Small bowel endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
44366	Small bowel endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
44369	Small bowel endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
44370	Small bowel endoscopy/stent		T	0384	27.8099	$1,915.43	.	$383.09
44372	Small bowel endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
44373	Small bowel endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
44376	Small bowel endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
44377	Small bowel endoscopy/biopsy		T	0142	10.1857	$701.55	$152.78	$140.31
44378	Small bowel endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
44379	S bowel endoscope w/stent		T	0384	27.8099	$1,915.43	.	$383.09
44380	Small bowel endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
44382	Small bowel endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
44383	Ileoscopy w/stent		T	0384	27.8099	$1,915.43	.	$383.09
44385	Endoscopy of bowel pouch		T	0143	9.3416	$643.41	$186.06	$128.69
44386	Endoscopy bowel pouch/biop		T	0143	9.3416	$643.41	$186.06	$128.69
44388	Colonoscopy		T	0143	9.3416	$643.41	$186.06	$128.69
44389	Colonoscopy with biopsy		T	0143	9.3416	$643.41	$186.06	$128.69
44390	Colonoscopy for foreign body		T	0143	9.3416	$643.41	$186.06	$128.69
44391	Colonoscopy for bleeding		T	0143	9.3416	$643.41	$186.06	$128.69
44392	Colonoscopy & polypectomy		T	0143	9.3416	$643.41	$186.06	$128.69
44393	Colonoscopy lesion removal		T	0143	9.3416	$643.41	$186.06	$128.69
44394	Colonoscopy w/snare		T	0143	9.3416	$643.41	$186.06	$128.69
44397	Colonoscopy w/stent		T	0384	27.8099	$1,915.43	.	$383.09
44500	Intro gastrointestinal tube		T	0121	6.3298	$435.97	.	$87.20
44602	Suture small intestine		C					
44603	Suture small intestine		C					
44604	Suture large intestine		C					
44605	Repair of bowel lesion		C					
44615	Intestinal stricturoplasty		C					
44620	Repair bowel opening		C					
44625	Repair bowel opening		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44626	Repair bowel opening		C					
44640	Repair bowel-skin fistula		C					
44650	Repair bowel fistula		C					
44660	Repair bowel-bladder fistula		C					
44661	Repair bowel-bladder fistula		C					
44680	Surgical revision intestine		C					
44700	Suspend bowel w/prosthesis		C					
44701	Intraop colon lavage add-on		N					
44715	Prepare donor intestine		C					
44720	Prep donor intestine/venous		C					
44721	Prep donor intestine/artery		C					
44799	Unlisted procedure intestine		T	0153	26.4829	$1,824.04	$375.24	$364.81
44800	Excision of bowel pouch		C					
44820	Excision of mesentery lesion		C					
44850	Repair of mesentery		C					
44899	Bowel surgery procedure		C					
44900	Drain app abscess open		C					
44901	Drain app abscess percut		T	0037	15.7009	$1,081.42	$228.76	$216.29
44950	Appendectomy		T	0153	26.4829	$1,824.04	$375.24	$364.81
44955	Appendectomy add-on		T	0153	26.4829	$1,824.04	$375.24	$364.81
44960	Appendectomy		C					
44970	Laparoscopy appendectomy		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
44979	Laparoscope proc app		T	0130	38.6514	$2,662.15	$659.53	$532.43
45000	Drainage of pelvic abscess		T	0155	16.1126	$1,109.77	.	$221.96
45005	Drainage of rectal abscess		T	0155	16.1126	$1,109.77	.	$221.96
45020	Drainage of rectal abscess		T	0155	16.1126	$1,109.77	.	$221.96
45100	Biopsy of rectum		T	0149	24.3450	$1,676.79	.	$335.36
45108	Removal of anorectal lesion		T	0149	24.3450	$1,676.79	.	$335.36
45110	Removal of rectum		C					
45111	Partial removal of rectum		C					
45112	Removal of rectum		C					
45113	Partial proctectomy		C					
45114	Partial removal of rectum		C					
45116	Partial removal of rectum		C					
45119	Remove rectum w/reservoir		C					
45120	Removal of rectum		C					
45121	Removal of rectum and colon		C					
45123	Partial proctectomy		C					
45126	Pelvic exenteration		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45130	Excision of rectal prolapse		C					
45135	Excision of rectal prolapse		C					
45136	Excise ileoanal reservior		C					
45150	Excision of rectal stricture		T	0149	24.3450	$1,676.79	.	$335.36
45160	Excision of rectal lesion		T	0149	24.3450	$1,676.79	.	$335.36
45171	Exc rect tum transanal part		T	0155	16.1126	$1,109.77	.	$221.96
45172	Exc rect tum transanal full		T	0149	24.3450	$1,676.79	.	$335.36
45190	Destruction rectal tumor		T	0149	24.3450	$1,676.79	.	$335.36
45300	Proctosigmoidoscopy dx		T	0146	5.7982	$399.36	.	$79.88
45303	Proctosigmoidoscopy dilate		T	0147	9.5044	$654.63	.	$130.93
45305	Proctosigmoidoscopy w/bx		T	0147	9.5044	$654.63	.	$130.93
45307	Proctosigmoidoscopy fb		T	0428	24.4042	$1,680.86	.	$336.18
45308	Proctosigmoidoscopy removal		T	0147	9.5044	$654.63	.	$130.93
45309	Proctosigmoidoscopy removal		T	0147	9.5044	$654.63	.	$130.93
45315	Proctosigmoidoscopy removal		T	0147	9.5044	$654.63	.	$130.93
45317	Proctosigmoidoscopy bleed		T	0147	9.5044	$654.63	.	$130.93
45320	Proctosigmoidoscopy ablate		T	0428	24.4042	$1,680.86	.	$336.18
45321	Proctosigmoidoscopy volvul		T	0428	24.4042	$1,680.86	.	$336.18
45327	Proctosigmoidoscopy w/stent		T	0384	27.8099	$1,915.43	.	$383.09
45330	Diagnostic sigmoidoscopy		T	0146	5.7982	$399.36	.	$79.88
45331	Sigmoidoscopy and biopsy		T	0146	5.7982	$399.36	.	$79.88
45332	Sigmoidoscopy w/fb removal		T	0146	5.7982	$399.36	.	$79.88
45333	Sigmoidoscopy & polypectomy		T	0147	9.5044	$654.63	.	$130.93
45334	Sigmoidoscopy for bleeding		T	0147	9.5044	$654.63	.	$130.93
45335	Sigmoidoscopy w/submuc inj		T	0146	5.7982	$399.36	.	$79.88
45337	Sigmoidoscopy & decompress		T	0146	5.7982	$399.36	.	$79.88
45338	Sigmoidoscopy w/tumr remove		T	0147	9.5044	$654.63	.	$130.93
45339	Sigmoidoscopy w/ablate tumr		T	0147	9.5044	$654.63	.	$130.93
45340	Sig w/balloon dilation		T	0147	9.5044	$654.63	.	$130.93
45341	Sigmoidoscopy w/ultrasound		T	0147	9.5044	$654.63	.	$130.93
45342	Sigmoidoscopy w/us guide bx		T	0147	9.5044	$654.63	.	$130.93
45345	Sigmoidoscopy w/stent		T	0384	27.8099	$1,915.43	.	$383.09
45355	Surgical colonoscopy		T	0143	9.3416	$643.41	$186.06	$128.69
45378	Diagnostic colonoscopy		T	0143	9.3416	$643.41	$186.06	$128.69
45379	Colonoscopy w/fb removal		T	0143	9.3416	$643.41	$186.06	$128.69
45380	Colonoscopy and biopsy		T	0143	9.3416	$643.41	$186.06	$128.69
45381	Colonoscopy submucous inj		T	0143	9.3416	$643.41	$186.06	$128.69
45382	Colonoscopy/control bleeding		T	0143	9.3416	$643.41	$186.06	$128.69
45383	Lesion removal colonoscopy		T	0143	9.3416	$643.41	$186.06	$128.69

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45384	Lesion remove colonoscopy		T	0143	9.3416	$643.41	$186.06	$128.69
45385	Lesion removal colonoscopy		T	0143	9.3416	$643.41	$186.06	$128.69
45386	Colonoscopy dilate stricture		T	0143	9.3416	$643.41	$186.06	$128.69
45387	Colonoscopy w/stent		T	0384	27.8099	$1,915.43	.	$383.09
45391	Colonoscopy w/endoscope us		T	0143	9.3416	$643.41	$186.06	$128.69
45392	Colonoscopy w/endoscopic fnb		T	0143	9.3416	$643.41	$186.06	$128.69
45395	Lap removal of rectum		C					
45397	Lap remove rectum w/pouch		C					
45400	Laparoscopic proc		C					
45402	Lap proctopexy w/sig resect		C					
45499	Laparoscope proc rectum		T	0130	38.6514	$2,662.15	$659.53	$532.43
45500	Repair of rectum		T	0149	24.3450	$1,676.79	.	$335.36
45505	Repair of rectum		T	0150	32.6594	$2,249.45	.	$449.89
45520	Treatment of rectal prolapse		T	0013	0.9103	$62.70	.	$12.54
45540	Correct rectal prolapse		C					
45541	Correct rectal prolapse		T	0150	32.6594	$2,249.45	.	$449.89
45550	Repair rectum/remove sigmoid		C					
45560	Repair of rectocele		T	0150	32.6594	$2,249.45	.	$449.89
45562	Exploration/repair of rectum		C					
45563	Exploration/repair of rectum		C					
45800	Repair rect/bladder fistula		C					
45805	Repair fistula w/colostomy		C					
45820	Repair rectourethral fistula		C					
45825	Repair fistula w/colostomy		C					
45900	Reduction of rectal prolapse		T	0148	6.0158	$414.34	.	$82.87
45905	Dilation of anal sphincter		T	0149	24.3450	$1,676.79	.	$335.36
45910	Dilation of rectal narrowing		T	0149	24.3450	$1,676.79	.	$335.36
45915	Remove rectal obstruction		T	0155	16.1126	$1,109.77	.	$221.96
45990	Surg dx exam anorectal		T	0149	24.3450	$1,676.79	.	$335.36
45999	Rectum surgery procedure		T	0148	6.0158	$414.34	.	$82.87
46020	Placement of seton		T	0149	24.3450	$1,676.79	.	$335.36
46030	Removal of rectal marker		T	0148	6.0158	$414.34	.	$82.87
46040	Incision of rectal abscess		T	0149	24.3450	$1,676.79	.	$335.36
46045	Incision of rectal abscess		T	0149	24.3450	$1,676.79	.	$335.36
46050	Incision of anal abscess		T	0155	16.1126	$1,109.77	.	$221.96
46060	Incision of rectal abscess		T	0149	24.3450	$1,676.79	.	$335.36
46070	Incision of anal septum		T	0155	16.1126	$1,109.77	.	$221.96
46080	Incision of anal sphincter		T	0149	24.3450	$1,676.79	.	$335.36
46083	Incise external hemorrhoid		T	0164	2.0369	$140.29	.	$28.06

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46200	Removal of anal fissure		T	0149	24.3450	$1,676.79	.	$335.36
46220	Excise anal ext tag/papilla		T	0155	16.1126	$1,109.77	.	$221.96
46221	Ligation of hemorrhoid(s)		T	0148	6.0158	$414.34	.	$82.87
46230	Removal of anal tags		T	0149	24.3450	$1,676.79	.	$335.36
46250	Remove ext hem groups 2+		T	0149	24.3450	$1,676.79	.	$335.36
46255	Remove int/ext hem 1 group		T	0149	24.3450	$1,676.79	.	$335.36
46257	Remove in/ex hem grp & fiss		T	0149	24.3450	$1,676.79	.	$335.36
46258	Remove in/ex hem grp w/fistu		T	0149	24.3450	$1,676.79	.	$335.36
46260	Remove in/ex hem groups 2+		T	0149	24.3450	$1,676.79	.	$335.36
46261	Remove in/ex hem grps & fiss		T	0149	24.3450	$1,676.79	.	$335.36
46262	Remove in/ex hem grps w/fist		T	0149	24.3450	$1,676.79	.	$335.36
46270	Remove anal fist subq		T	0149	24.3450	$1,676.79	.	$335.36
46275	Remove anal fist inter		T	0149	24.3450	$1,676.79	.	$335.36
46280	Remove anal fist complex		T	0149	24.3450	$1,676.79	.	$335.36
46285	Remove anal fist 2 stage		T	0149	24.3450	$1,676.79	.	$335.36
46288	Repair anal fistula		T	0149	24.3450	$1,676.79	.	$335.36
46320	Removal of hemorrhoid clot		T	0149	24.3450	$1,676.79	.	$335.36
46500	Injection into hemorrhoid(s)		T	0155	16.1126	$1,109.77	.	$221.96
46505	Chemodenervation anal musc		T	0149	24.3450	$1,676.79	.	$335.36
46600	Diagnostic anoscopy		X	0340	0.6712	$46.23	.	$9.25
46604	Anoscopy and dilation		T	0147	9.5044	$654.63	.	$130.93
46606	Anoscopy and biopsy		T	0146	5.7982	$399.36	.	$79.88
46608	Anoscopy remove for body		T	0147	9.5044	$654.63	.	$130.93
46610	Anoscopy remove lesion		T	0428	24.4042	$1,680.86	.	$336.18
46611	Anoscopy		T	0147	9.5044	$654.63	.	$130.93
46612	Anoscopy remove lesions		T	0428	24.4042	$1,680.86	.	$336.18
46614	Anoscopy control bleeding		T	0146	5.7982	$399.36	.	$79.88
46615	Anoscopy		T	0428	24.4042	$1,680.86	.	$336.18
46700	Repair of anal stricture		T	0149	24.3450	$1,676.79	.	$335.36
46705	Repair of anal stricture		C					
46706	Repr of anal fistula w/glue		T	0150	32.6594	$2,249.45	.	$449.89
46707	Repair anorectal fist w/plug		T	0150	32.6594	$2,249.45	.	$449.89
46710	Repr per/vag pouch sngl proc		C					
46712	Repr per/vag pouch dbl proc		C					
46715	Rep perf anoper fistu		C					
46716	Rep perf anoper/vestib fistu		C					
46730	Construction of absent anus		C					
46735	Construction of absent anus		C					
46740	Construction of absent anus		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46742	Repair of imperforated anus		C					
46744	Repair of cloacal anomaly		C					
46746	Repair of cloacal anomaly		C					
46748	Repair of cloacal anomaly		C					
46750	Repair of anal sphincter		T	0150	32.6594	$2,249.45	.	$449.89
46751	Repair of anal sphincter		C					
46753	Reconstruction of anus		T	0149	24.3450	$1,676.79	.	$335.36
46754	Removal of suture from anus		T	0149	24.3450	$1,676.79	.	$335.36
46760	Repair of anal sphincter		T	0150	32.6594	$2,249.45	.	$449.89
46761	Repair of anal sphincter		T	0150	32.6594	$2,249.45	.	$449.89
46762	Implant artificial sphincter		T	0150	32.6594	$2,249.45	.	$449.89
46900	Destruction anal lesion(s)		T	0016	2.7318	$188.16	.	$37.64
46910	Destruction anal lesion(s)		T	0017	21.7969	$1,501.28	.	$300.26
46916	Cryosurgery anal lesion(s)		T	0015	1.4975	$103.14	.	$20.63
46917	Laser surgery anal lesions		T	0017	21.7969	$1,501.28	.	$300.26
46922	Excision of anal lesion(s)		T	0017	21.7969	$1,501.28	.	$300.26
46924	Destruction anal lesion(s)		T	0017	21.7969	$1,501.28	.	$300.26
46930	Destroy internal hemorrhoids		T	0148	6.0158	$414.34	.	$82.87
46940	Treatment of anal fissure		T	0149	24.3450	$1,676.79	.	$335.36
46942	Treatment of anal fissure		T	0148	6.0158	$414.34	.	$82.87
46945	Remove by ligat int hem grp		T	0155	16.1126	$1,109.77	.	$221.96
46946	Remove by ligat int hem grps		T	0155	16.1126	$1,109.77	.	$221.96
46947	Hemorrhoidopexy by stapling		T	0150	32.6594	$2,249.45	.	$449.89
46999	Anus surgery procedure		T	0148	6.0158	$414.34	.	$82.87
47000	Needle biopsy of liver		T	0685	9.7353	$670.53	.	$134.11
47001	Needle biopsy liver add-on		N					
47010	Open drainage liver lesion		C					
47011	Percut drain liver lesion		T	0037	15.7009	$1,081.42	$228.76	$216.29
47015	Inject/aspirate liver cyst		C					
47100	Wedge biopsy of liver		C					
47120	Partial removal of liver		C					
47122	Extensive removal of liver		C					
47125	Partial removal of liver		C					
47130	Partial removal of liver		C					
47133	Removal of donor liver		C					
47135	Transplantation of liver		C					
47136	Transplantation of liver		C					
47140	Partial removal donor liver		C					
47141	Partial removal donor liver		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47142	Partial removal donor liver		C					
47143	Prep donor liver whole		C					
47144	Prep donor liver 3-segment		C					
47145	Prep donor liver lobe split		C					
47146	Prep donor liver/venous		C					
47147	Prep donor liver/arterial		C					
47300	Surgery for liver lesion		C					
47350	Repair liver wound		C					
47360	Repair liver wound		C					
47361	Repair liver wound		C					
47362	Repair liver wound		C					
47370	Laparo ablate liver tumor rf		T	0174	113.9757	$7,850.19	$2,064.24	$1,570.04
47371	Laparo ablate liver cryosurg		T	0174	113.9757	$7,850.19	$2,064.24	$1,570.04
47379	Laparoscope procedure liver		T	0130	38.6514	$2,662.15	$659.53	$532.43
47380	Open ablate liver tumor rf		C					
47381	Open ablate liver tumor cryo		C					
47382	Percut ablate liver rf		T	0423	56.5664	$3,896.07	.	$779.22
47399	Liver surgery procedure		T	0004	4.5843	$315.75	.	$63.15
47400	Incision of liver duct		C					
47420	Incision of bile duct		C					
47425	Incision of bile duct		C					
47460	Incise bile duct sphincter		C					
47480	Incision of gallbladder		C					
47490	Incision of gallbladder		T	0152	31.7356	$2,185.82	.	$437.17
47500	Injection for liver x-rays		N					
47505	Injection for liver x-rays		N					
47510	Insert catheter bile duct		T	0152	31.7356	$2,185.82	.	$437.17
47511	Insert bile duct drain		T	0152	31.7356	$2,185.82	.	$437.17
47525	Change bile duct catheter		T	0427	16.3172	$1,123.86	.	$224.78
47530	Revise/reinsert bile tube		T	0427	16.3172	$1,123.86	.	$224.78
47550	Bile duct endoscopy add-on		C					
47552	Biliary endoscopy thru skin		T	0152	31.7356	$2,185.82	.	$437.17
47553	Biliary endoscopy thru skin		T	0152	31.7356	$2,185.82	.	$437.17
47554	Biliary endoscopy thru skin		T	0152	31.7356	$2,185.82	.	$437.17
47555	Biliary endoscopy thru skin		T	0152	31.7356	$2,185.82	.	$437.17
47556	Biliary endoscopy thru skin		T	0152	31.7356	$2,185.82	.	$437.17
47560	Laparoscopy w/cholangio		T	0130	38.6514	$2,662.15	$659.53	$532.43
47561	Laparo w/cholangio/biopsy		T	0130	38.6514	$2,662.15	$659.53	$532.43
47562	Laparoscopic cholecystectomy		T	0131	47.8453	$3,295.39	$1,001.89	$659.08

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47563	Laparo cholecystectomy/graph		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
47564	Laparo cholecystectomy/explr		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
47570	Laparo cholecystoenterostomy		C					
47579	Laparoscope proc biliary		T	0130	38.6514	$2,662.15	$659.53	$532.43
47600	Removal of gallbladder		C					
47605	Removal of gallbladder		C					
47610	Removal of gallbladder		C					
47612	Removal of gallbladder		C					
47620	Removal of gallbladder		C					
47630	Remove bile duct stone		T	0152	31.7356	$2,185.82	.	$437.17
47700	Exploration of bile ducts		C					
47701	Bile duct revision		C					
47711	Excision of bile duct tumor		C					
47712	Excision of bile duct tumor		C					
47715	Excision of bile duct cyst		C					
47720	Fuse gallbladder & bowel		C					
47721	Fuse upper gi structures		C					
47740	Fuse gallbladder & bowel		C					
47741	Fuse gallbladder & bowel		C					
47760	Fuse bile ducts and bowel		C					
47765	Fuse liver ducts & bowel		C					
47780	Fuse bile ducts and bowel		C					
47785	Fuse bile ducts and bowel		C					
47800	Reconstruction of bile ducts		C					
47801	Placement bile duct support		C					
47802	Fuse liver duct & intestine		C					
47900	Suture bile duct injury		C					
47999	Bile tract surgery procedure		T	0152	31.7356	$2,185.82	.	$437.17
48000	Drainage of abdomen		C					
48001	Placement of drain pancreas		C					
48020	Removal of pancreatic stone		C					
48100	Biopsy of pancreas open		C					
48102	Needle biopsy pancreas		T	0685	9.7353	$670.53	.	$134.11
48105	Resect/debride pancreas		C					
48120	Removal of pancreas lesion		C					
48140	Partial removal of pancreas		C					
48145	Partial removal of pancreas		C					
48146	Pancreatectomy		C					
48148	Removal of pancreatic duct		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
48150	Partial removal of pancreas		C					
48152	Pancreatectomy		C					
48153	Pancreatectomy		C					
48154	Pancreatectomy		C					
48155	Removal of pancreas		C					
48160	Pancreas removal/transplant		E					
48400	Injection intraop add-on		C					
48500	Surgery of pancreatic cyst		C					
48510	Drain pancreatic pseudocyst		C					
48511	Drain pancreatic pseudocyst		T	0037	15.7009	$1,081.42	$228.76	$216.29
48520	Fuse pancreas cyst and bowel		C					
48540	Fuse pancreas cyst and bowel		C					
48545	Pancreatorrhaphy		C					
48547	Duodenal exclusion		C					
48548	Fuse pancreas and bowel		C					
48550	Donor pancreatectomy		E					
48551	Prep donor pancreas		C					
48552	Prep donor pancreas/venous		C					
48554	Transpl allograft pancreas		C					
48556	Removal allograft pancreas		C					
48999	Pancreas surgery procedure		T	0004	4.5843	$315.75	.	$63.15
49000	Exploration of abdomen		C					
49002	Reopening of abdomen		C					
49010	Exploration behind abdomen		C					
49020	Drain abdominal abscess		C					
49021	Drain abdominal abscess		T	0037	15.7009	$1,081.42	$228.76	$216.29
49040	Drain open abdom abscess		C					
49041	Drain percut abdom abscess		T	0037	15.7009	$1,081.42	$228.76	$216.29
49060	Drain open retrop abscess		C					
49061	Drain percut retroper absc		T	0037	15.7009	$1,081.42	$228.76	$216.29
49062	Drain to peritoneal cavity		C					
49080	Puncture peritoneal cavity		T	0070	5.5631	$383.16	.	$76.64
49081	Removal of abdominal fluid		T	0070	5.5631	$383.16	.	$76.64
49180	Biopsy abdominal mass		T	0685	9.7353	$670.53	.	$134.11
49203	Exc abd tum 5 cm or less		C					
49204	Exc abd tum over 5 cm		C					
49205	Exc abd tum over 10 cm		C					
49215	Excise sacral spine tumor		C					
49220	Multiple surgery abdomen		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49250	Excision of umbilicus		T	0153	26.4829	$1,824.04	$375.24	$364.81
49255	Removal of omentum		C					
49320	Diag laparo separate proc		T	0130	38.6514	$2,662.15	$659.53	$532.43
49321	Laparoscopy biopsy		T	0130	38.6514	$2,662.15	$659.53	$532.43
49322	Laparoscopy aspiration		T	0130	38.6514	$2,662.15	$659.53	$532.43
49323	Laparo drain lymphocele		T	0130	38.6514	$2,662.15	$659.53	$532.43
49324	Lap insert tunnel ip cath		T	0130	38.6514	$2,662.15	$659.53	$532.43
49325	Lap revision perm ip cath		T	0130	38.6514	$2,662.15	$659.53	$532.43
49326	Lap w/omentopexy add-on		T	0130	38.6514	$2,662.15	$659.53	$532.43
49327	Lap ins device for rt	NI	T	0130	38.6514	$2,662.15	$659.53	$532.43
49329	Laparo proc abdm/per/oment		T	0130	38.6514	$2,662.15	$659.53	$532.43
49400	Air injection into abdomen		N					
49402	Remove foreign body adbomen		T	0153	26.4829	$1,824.04	$375.24	$364.81
49411	Ins mark abd/pel for rt perq		X	0310	13.4552	$926.74	$325.27	$185.35
49412	Ins device for rt guide open	NI	C					
49418	Insert tun ip cath perc	NI	T	0652	31.0010	$2,135.22	.	$427.05
49419	Insert tun ip cath w/port		T	0115	35.0863	$2,416.60	.	$483.32
49420	Insert abdom drain, temp	CH	D					
49421	Ins tun ip cath for dial opn		T	0652	31.0010	$2,135.22	.	$427.05
49422	Remove tunneled ip cath		T	0105	22.7342	$1,565.84	.	$313.17
49423	Exchange drainage catheter		T	0427	16.3172	$1,123.86	.	$224.78
49424	Assess cyst contrast inject		N					
49425	Insert abdomen-venous drain		C					
49426	Revise abdomen-venous shunt		T	0153	26.4829	$1,824.04	$375.24	$364.81
49427	Injection abdominal shunt		N					
49428	Ligation of shunt		C					
49429	Removal of shunt		T	0105	22.7342	$1,565.84	.	$313.17
49435	Insert subq exten to ip cath		T	0427	16.3172	$1,123.86	.	$224.78
49436	Embedded ip cath exit-site		T	0427	16.3172	$1,123.86	.	$224.78
49440	Place gastrostomy tube perc		T	0141	8.8816	$611.73	$143.38	$122.35
49441	Place duod/jej tube perc		T	0141	8.8816	$611.73	$143.38	$122.35
49442	Place cecostomy tube perc		T	0155	16.1126	$1,109.77	.	$221.96
49446	Change g-tube to g-j perc		T	0141	8.8816	$611.73	$143.38	$122.35
49450	Replace g/c tube perc		T	0121	6.3298	$435.97	.	$87.20
49451	Replace duod/jej tube perc		T	0121	6.3298	$435.97	.	$87.20
49452	Replace g-j tube perc		T	0121	6.3298	$435.97	.	$87.20
49460	Fix g/colon tube w/device		T	0121	6.3298	$435.97		$87.20
49465	Fluoro exam of g/colon tube	CH	Q1	0277	2.0614	$141.98	$53.90	$28.40
49491	Rpr hern preemie reduc		T	0154	33.0791	$2,278.36	$464.85	$455.68

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49492	Rpr ing hern premie blocked		T	0154	33.0791	$2,278.36	$464.85	$455.68
49495	Rpr ing hernia baby reduc		T	0154	33.0791	$2,278.36	$464.85	$455.68
49496	Rpr ing hernia baby blocked		T	0154	33.0791	$2,278.36	$464.85	$455.68
49500	Rpr ing hernia init reduce		T	0154	33.0791	$2,278.36	$464.85	$455.68
49501	Rpr ing hernia init blocked		T	0154	33.0791	$2,278.36	$464.85	$455.68
49505	Prp i/hern init reduc >5 yr		T	0154	33.0791	$2,278.36	$464.85	$455.68
49507	Prp i/hern init block >5 yr		T	0154	33.0791	$2,278.36	$464.85	$455.68
49520	Rerepair ing hernia reduce		T	0154	33.0791	$2,278.36	$464.85	$455.68
49521	Rerepair ing hernia blocked		T	0154	33.0791	$2,278.36	$464.85	$455.68
49525	Repair ing hernia sliding		T	0154	33.0791	$2,278.36	$464.85	$455.68
49540	Repair lumbar hernia		T	0154	33.0791	$2,278.36	$464.85	$455.68
49550	Rpr rem hernia init reduce		T	0154	33.0791	$2,278.36	$464.85	$455.68
49553	Rpr fem hernia init blocked		T	0154	33.0791	$2,278.36	$464.85	$455.68
49555	Rerepair fem hernia reduce		T	0154	33.0791	$2,278.36	$464.85	$455.68
49557	Rerepair fem hernia blocked		T	0154	33.0791	$2,278.36	$464.85	$455.68
49560	Rpr ventral hern init reduc		T	0154	33.0791	$2,278.36	$464.85	$455.68
49561	Rpr ventral hern init block		T	0154	33.0791	$2,278.36	$464.85	$455.68
49565	Rerepair ventrl hern reduce		T	0154	33.0791	$2,278.36	$464.85	$455.68
49566	Rerepair ventrl hern block		T	0154	33.0791	$2,278.36	$464.85	$455.68
49568	Hernia repair w/mesh		T	0154	33.0791	$2,278.36	$464.85	$455.68
49570	Rpr epigastric hern reduce		T	0154	33.0791	$2,278.36	$464.85	$455.68
49572	Rpr epigastric hern blocked		T	0154	33.0791	$2,278.36	$464.85	$455.68
49580	Rpr umbil hern reduc < 5 yr		T	0154	33.0791	$2,278.36	$464.85	$455.68
49582	Rpr umbil hern block < 5 yr		T	0154	33.0791	$2,278.36	$464.85	$455.68
49585	Rpr umbil hern reduc > 5 yr		T	0154	33.0791	$2,278.36	$464.85	$455.68
49587	Rpr umbil hern block > 5 yr		T	0154	33.0791	$2,278.36	$464.85	$455.68
49590	Repair spigelian hernia		T	0154	33.0791	$2,278.36	$464.85	$455.68
49600	Repair umbilical lesion		T	0154	33.0791	$2,278.36	$464.85	$455.68
49605	Repair umbilical lesion		C					
49606	Repair umbilical lesion		C					
49610	Repair umbilical lesion		C					
49611	Repair umbilical lesion		C					
49650	Lap ing hernia repair init		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
49651	Lap ing hernia repair recur		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
49652	Lap vent/abd hernia repair		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
49653	Lap vent/abd hern proc comp		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
49654	Lap inc hernia repair		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
49655	Lap inc hern repair comp		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
49656	Lap inc hernia repair recur		T	0132	71.0980	$4,896.95	$1,236.99	$979.39

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49657	Lap inc hern recur comp		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
49659	Laparo proc hernia repair		T	0130	38.6514	$2,662.15	$659.53	$532.43
49900	Repair of abdominal wall		C					
49904	Omental flap extra-abdom		C					
49905	Omental flap intra-abdom		C					
49906	Free omental flap microvasc		C					
49999	Abdomen surgery procedure		T	0153	26.4829	$1,824.04	$375.24	$364.81
50010	Exploration of kidney		C					
50020	Renal abscess open drain		T	0162	26.3334	$1,813.74	.	$362.75
50021	Renal abscess percut drain		T	0037	15.7009	$1,081.42	$228.76	$216.29
50040	Drainage of kidney		C					
50045	Exploration of kidney		C					
50060	Removal of kidney stone		C					
50065	Incision of kidney		C					
50070	Incision of kidney		C					
50075	Removal of kidney stone		C					
50080	Removal of kidney stone		T	0429	46.4709	$3,200.73	.	$640.15
50081	Removal of kidney stone		T	0429	46.4709	$3,200.73	.	$640.15
50100	Revise kidney blood vessels		C					
50120	Exploration of kidney		C					
50125	Explore and drain kidney		C					
50130	Removal of kidney stone		C					
50135	Exploration of kidney		C					
50200	Renal biopsy perq		T	0685	9.7353	$670.53	.	$134.11
50205	Renal biopsy open		C					
50220	Remove kidney open		C					
50225	Removal kidney open complex		C					
50230	Removal kidney open radical		C					
50234	Removal of kidney & ureter		C					
50236	Removal of kidney & ureter		C					
50240	Partial removal of kidney		C					
50250	Cryoablate renal mass open		C					
50280	Removal of kidney lesion		C					
50290	Removal of kidney lesion		C					
50300	Remove cadaver donor kidney		C					
50320	Remove kidney living donor		C					
50323	Prep cadaver renal allograft		C					
50325	Prep donor renal graft		C					
50327	Prep renal graft/venous		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50328	Prep renal graft/arterial		C					
50329	Prep renal graft/ureteral		C					
50340	Removal of kidney		C					
50360	Transplantation of kidney		C					
50365	Transplantation of kidney		C					
50370	Remove transplanted kidney		C					
50380	Reimplantation of kidney		C					
50382	Change ureter stent percut		T	0162	26.3334	$1,813.74	.	$362.75
50384	Remove ureter stent percut		T	0161	17.5738	$1,210.41	.	$242.09
50385	Change stent via transureth		T	0162	26.3334	$1,813.74	.	$362.75
50386	Remove stent via transureth		T	0160	7.4406	$512.48	.	$102.50
50387	Change ext/int ureter stent		T	0427	16.3172	$1,123.86	.	$224.78
50389	Remove renal tube w/fluoro		T	0160	7.4406	$512.48	.	$102.50
50390	Drainage of kidney lesion		T	0685	9.7353	$670.53	.	$134.11
50391	Instll rx agnt into rnal tub		T	0126	1.1110	$76.52	$16.21	$15.31
50392	Insert kidney drain		T	0161	17.5738	$1,210.41	.	$242.09
50393	Insert ureteral tube		T	0162	26.3334	$1,813.74	.	$362.75
50394	Injection for kidney x-ray		N					
50395	Create passage to kidney		T	0162	26.3334	$1,813.74	.	$362.75
50396	Measure kidney pressure		T	0164	2.0369	$140.29	.	$28.06
50398	Change kidney tube		T	0427	16.3172	$1,123.86	.	$224.78
50400	Revision of kidney/ureter		C					
50405	Revision of kidney/ureter		C					
50500	Repair of kidney wound		C					
50520	Close kidney-skin fistula		C					
50525	Repair renal-abdomen fistula		C					
50526	Repair renal-abdomen fistula		C					
50540	Revision of horseshoe kidney		C					
50541	Laparo ablate renal cyst		T	0130	38.6514	$2,662.15	$659.53	$532.43
50542	Laparo ablate renal mass		T	0174	113.9757	$7,850.19	$2,064.24	$1,570.04
50543	Laparo partial nephrectomy		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
50544	Laparoscopy pyeloplasty		T	0130	38.6514	$2,662.15	$659.53	$532.43
50545	Laparo radical nephrectomy		C					
50546	Laparoscopic nephrectomy		C					
50547	Laparo removal donor kidney		C					
50548	Laparo remove w/ureter		C					
50549	Laparoscope proc renal		T	0130	38.6514	$2,662.15	$659.53	$532.43
50551	Kidney endoscopy		T	0160	7.4406	$512.48	.	$102.50
50553	Kidney endoscopy		T	0162	26.3334	$1,813.74	.	$362.75

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50555	Kidney endoscopy & biopsy		T	0160	7.4406	$512.48	.	$102.50
50557	Kidney endoscopy & treatment		T	0162	26.3334	$1,813.74	.	$362.75
50561	Kidney endoscopy & treatment		T	0162	26.3334	$1,813.74	.	$362.75
50562	Renal scope w/tumor resect		T	0160	7.4406	$512.48	.	$102.50
50570	Kidney endoscopy		T	0160	7.4406	$512.48	.	$102.50
50572	Kidney endoscopy		T	0160	7.4406	$512.48	.	$102.50
50574	Kidney endoscopy & biopsy		T	0160	7.4406	$512.48	.	$102.50
50575	Kidney endoscopy		T	0163	37.3582	$2,573.08	.	$514.62
50576	Kidney endoscopy & treatment		T	0161	17.5738	$1,210.41	.	$242.09
50580	Kidney endoscopy & treatment		T	0161	17.5738	$1,210.41	.	$242.09
50590	Fragmenting of kidney stone		T	0169	41.9797	$2,891.39	$997.74	$578.28
50592	Perc rf ablate renal tumor		T	0423	56.5664	$3,896.07	.	$779.22
50593	Perc cryo ablate renal tum		T	0423	56.5664	$3,896.07	.	$779.22
50600	Exploration of ureter		C					
50605	Insert ureteral support		C					
50610	Removal of ureter stone		C					
50620	Removal of ureter stone		C					
50630	Removal of ureter stone		C					
50650	Removal of ureter		C					
50660	Removal of ureter		C					
50684	Injection for ureter x-ray		N					
50686	Measure ureter pressure		T	0126	1.1110	$76.52	$16.21	$15.31
50688	Change of ureter tube/stent		T	0427	16.3172	$1,123.86	.	$224.78
50690	Injection for ureter x-ray		N					
50700	Revision of ureter		C					
50715	Release of ureter		C					
50722	Release of ureter		C					
50725	Release/revise ureter		C					
50727	Revise ureter		T	0165	20.0886	$1,383.62	.	$276.73
50728	Revise ureter		C					
50740	Fusion of ureter & kidney		C					
50750	Fusion of ureter & kidney		C					
50760	Fusion of ureters		C					
50770	Splicing of ureters		C					
50780	Reimplant ureter in bladder		C					
50782	Reimplant ureter in bladder		C					
50783	Reimplant ureter in bladder		C					
50785	Reimplant ureter in bladder		C					
50800	Implant ureter in bowel		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50810	Fusion of ureter & bowel		C					
50815	Urine shunt to intestine		C					
50820	Construct bowel bladder		C					
50825	Construct bowel bladder		C					
50830	Revise urine flow		C					
50840	Replace ureter by bowel		C					
50845	Appendico-vesicostomy		C					
50860	Transplant ureter to skin		C					
50900	Repair of ureter		C					
50920	Closure ureter/skin fistula		C					
50930	Closure ureter/bowel fistula		C					
50940	Release of ureter		C					
50945	Laparoscopy ureterolithotomy		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
50947	Laparo new ureter/bladder		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
50948	Laparo new ureter/bladder		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
50949	Laparoscope proc ureter		T	0130	38.6514	$2,662.15	$659.53	$532.43
50951	Endoscopy of ureter		T	0160	7.4406	$512.48	.	$102.50
50953	Endoscopy of ureter		T	0160	7.4406	$512.48	.	$102.50
50955	Ureter endoscopy & biopsy		T	0162	26.3334	$1,813.74	.	$362.75
50957	Ureter endoscopy & treatment		T	0162	26.3334	$1,813.74	.	$362.75
50961	Ureter endoscopy & treatment		T	0162	26.3334	$1,813.74	.	$362.75
50970	Ureter endoscopy		T	0160	7.4406	$512.48	.	$102.50
50972	Ureter endoscopy & catheter		T	0160	7.4406	$512.48	.	$102.50
50974	Ureter endoscopy & biopsy		T	0161	17.5738	$1,210.41	.	$242.09
50976	Ureter endoscopy & treatment		T	0161	17.5738	$1,210.41	.	$242.09
50980	Ureter endoscopy & treatment		T	0162	26.3334	$1,813.74	.	$362.75
51020	Incise & treat bladder		T	0162	26.3334	$1,813.74	.	$362.75
51030	Incise & treat bladder		T	0162	26.3334	$1,813.74	.	$362.75
51040	Incise & drain bladder		T	0162	26.3334	$1,813.74	.	$362.75
51045	Incise bladder/drain ureter		T	0160	7.4406	$512.48	.	$102.50
51050	Removal of bladder stone		T	0162	26.3334	$1,813.74	.	$362.75
51060	Removal of ureter stone		T	0163	37.3582	$2,573.08	.	$514.62
51065	Remove ureter calculus		T	0162	26.3334	$1,813.74	.	$362.75
51080	Drainage of bladder abscess		T	0008	20.1996	$1,391.27	.	$278.26
51100	Drain bladder by needle		T	0164	2.0369	$140.29	.	$28.06
51101	Drain bladder by trocar/cath		T	0126	1.1110	$76.52	$16.21	$15.31
51102	Drain bl w/cath insertion		T	0165	20.0886	$1,383.62	.	$276.73
51500	Removal of bladder cyst		T	0154	33.0791	$2,278.36	$464.85	$455.68
51520	Removal of bladder lesion		T	0162	26.3334	$1,813.74	.	$362.75

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
51525	Removal of bladder lesion		C					
51530	Removal of bladder lesion		C					
51535	Repair of ureter lesion		T	0162	26.3334	$1,813.74	.	$362.75
51550	Partial removal of bladder		C					
51555	Partial removal of bladder		C					
51565	Revise bladder & ureter(s)		C					
51570	Removal of bladder		C					
51575	Removal of bladder & nodes		C					
51580	Remove bladder/revise tract		C					
51585	Removal of bladder & nodes		C					
51590	Remove bladder/revise tract		C					
51595	Remove bladder/revise tract		C					
51596	Remove bladder/create pouch		C					
51597	Removal of pelvic structures		C					
51600	Injection for bladder x-ray		N					
51605	Preparation for bladder xray		N					
51610	Injection for bladder x-ray		N					
51700	Irrigation of bladder		T	0164	2.0369	$140.29	.	$28.06
51701	Insert bladder catheter		X	0340	0.6712	$46.23	.	$9.25
51702	Insert temp bladder cath		X	0340	0.6712	$46.23	.	$9.25
51703	Insert bladder cath complex		T	0126	1.1110	$76.52	$16.21	$15.31
51705	Change of bladder tube		T	0164	2.0369	$140.29	.	$28.06
51710	Change of bladder tube		T	0121	6.3298	$435.97	.	$87.20
51715	Endoscopic injection/implant		T	0168	32.6605	$2,249.52	.	$449.91
51720	Treatment of bladder lesion		T	0156	3.2116	$221.20	.	$44.24
51725	Simple cystometrogram		T	0156	3.2116	$221.20	.	$44.24
51726	Complex cystometrogram		T	0156	3.2116	$221.20	.	$44.24
51727	Cystometrogram w/up		T	0156	3.2116	$221.20	.	$44.24
51728	Cystometrogram w/vp		T	0156	3.2116	$221.20	.	$44.24
51729	Cystometrogram w/vp&up		T	0156	3.2116	$221.20	.	$44.24
51736	Urine flow measurement	CH	X	0340	0.6712	$46.23	.	$9.25
51741	Electro-uroflowmetry first		T	0126	1.1110	$76.52	$16.21	$15.31
51784	Anal/urinary muscle study		T	0126	1.1110	$76.52	$16.21	$15.31
51785	Anal/urinary muscle study		T	0164	2.0369	$140.29	.	$28.06
51792	Urinary reflex study		T	0126	1.1110	$76.52	$16.21	$15.31
51797	Intraabdominal pressure test		T	0164	2.0369	$140.29	.	$28.06
51798	Us urine capacity measure		X	0340	0.6712	$46.23	.	$9.25
51800	Revision of bladder/urethra		C					
51820	Revision of urinary tract		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
51840	Attach bladder/urethra		C					
51841	Attach bladder/urethra		C					
51845	Repair bladder neck		T	0202	45.3938	$3,126.54	$981.50	$625.31
51860	Repair of bladder wound		T	0162	26.3334	$1,813.74	.	$362.75
51865	Repair of bladder wound		C					
51880	Repair of bladder opening		T	0162	26.3334	$1,813.74	.	$362.75
51900	Repair bladder/vagina lesion		C					
51920	Close bladder-uterus fistula		C					
51925	Hysterectomy/bladder repair		C					
51940	Correction of bladder defect		C					
51960	Revision of bladder & bowel		C					
51980	Construct bladder opening		C					
51990	Laparo urethral suspension		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
51992	Laparo sling operation		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
51999	Laparoscope proc bla		T	0130	38.6514	$2,662.15	$659.53	$532.43
52000	Cystoscopy		T	0160	7.4406	$512.48	.	$102.50
52001	Cystoscopy removal of clots		T	0161	17.5738	$1,210.41	.	$242.09
52005	Cystoscopy & ureter catheter		T	0162	26.3334	$1,813.74	.	$362.75
52007	Cystoscopy and biopsy		T	0162	26.3334	$1,813.74	.	$362.75
52010	Cystoscopy & duct catheter		T	0160	7.4406	$512.48	.	$102.50
52204	Cystoscopy w/biopsy(s)		T	0162	26.3334	$1,813.74	.	$362.75
52214	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52224	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52234	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52235	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52240	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52250	Cystoscopy and radiotracer		T	0162	26.3334	$1,813.74	.	$362.75
52260	Cystoscopy and treatment		T	0161	17.5738	$1,210.41	.	$242.09
52265	Cystoscopy and treatment		T	0160	7.4406	$512.48	.	$102.50
52270	Cystoscopy & revise urethra		T	0161	17.5738	$1,210.41	.	$242.09
52275	Cystoscopy & revise urethra		T	0162	26.3334	$1,813.74	.	$362.75
52276	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52277	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52281	Cystoscopy and treatment		T	0161	17.5738	$1,210.41	.	$242.09
52282	Cystoscopy implant stent		T	0163	37.3582	$2,573.08	.	$514.62
52283	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52285	Cystoscopy and treatment		T	0161	17.5738	$1,210.41	.	$242.09
52290	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52300	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
52301	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52305	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52310	Cystoscopy and treatment		T	0161	17.5738	$1,210.41	.	$242.09
52315	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52317	Remove bladder stone		T	0162	26.3334	$1,813.74	.	$362.75
52318	Remove bladder stone		T	0162	26.3334	$1,813.74	.	$362.75
52320	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52325	Cystoscopy stone removal		T	0162	26.3334	$1,813.74	.	$362.75
52327	Cystoscopy inject material		T	0163	37.3582	$2,573.08	.	$514.62
52330	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52332	Cystoscopy and treatment		T	0162	26.3334	$1,813.74	.	$362.75
52334	Create passage to kidney		T	0162	26.3334	$1,813.74	.	$362.75
52341	Cysto w/ureter stricture tx		T	0162	26.3334	$1,813.74	.	$362.75
52342	Cysto w/up stricture tx		T	0162	26.3334	$1,813.74	.	$362.75
52343	Cysto w/renal stricture tx		T	0162	26.3334	$1,813.74	.	$362.75
52344	Cysto/uretero stricture tx		T	0162	26.3334	$1,813.74	.	$362.75
52345	Cysto/uretero w/up stricture		T	0162	26.3334	$1,813.74	.	$362.75
52346	Cystouretero w/renal strict		T	0162	26.3334	$1,813.74	.	$362.75
52351	Cystouretero & or pyeloscope		T	0162	26.3334	$1,813.74	.	$362.75
52352	Cystouretero w/stone remove		T	0162	26.3334	$1,813.74	.	$362.75
52353	Cystouretero w/lithotripsy		T	0163	37.3582	$2,573.08	.	$514.62
52354	Cystouretero w/biopsy		T	0162	26.3334	$1,813.74	.	$362.75
52355	Cystouretero w/excise tumor		T	0162	26.3334	$1,813.74	.	$362.75
52400	Cystouretero w/congen repr		T	0162	26.3334	$1,813.74	.	$362.75
52402	Cystourethro cut ejacul duct		T	0162	26.3334	$1,813.74	.	$362.75
52450	Incision of prostate		T	0162	26.3334	$1,813.74	.	$362.75
52500	Revision of bladder neck		T	0162	26.3334	$1,813.74	.	$362.75
52601	Prostatectomy (TURP)		T	0163	37.3582	$2,573.08	.	$514.62
52630	Remove prostate regrowth		T	0163	37.3582	$2,573.08	.	$514.62
52640	Relieve bladder contracture		T	0162	26.3334	$1,813.74	.	$362.75
52647	Laser surgery of prostate		T	0429	46.4709	$3,200.73	.	$640.15
52648	Laser surgery of prostate		T	0429	46.4709	$3,200.73	.	$640.15
52649	Prostate laser enucleation		T	0429	46.4709	$3,200.73	.	$640.15
52700	Drainage of prostate abscess		T	0162	26.3334	$1,813.74	.	$362.75
53000	Incision of urethra		T	0166	21.6923	$1,494.08	.	$298.82
53010	Incision of urethra		T	0166	21.6923	$1,494.08	.	$298.82
53020	Incision of urethra		T	0166	21.6923	$1,494.08	.	$298.82
53025	Incision of urethra		T	0166	21.6923	$1,494.08	.	$298.82
53040	Drainage of urethra abscess		T	0166	21.6923	$1,494.08	.	$298.82

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
53060	Drainage of urethra abscess		T	0166	21.6923	$1,494.08	.	$298.82
53080	Drainage of urinary leakage		T	0166	21.6923	$1,494.08	.	$298.82
53085	Drainage of urinary leakage		T	0166	21.6923	$1,494.08	.	$298.82
53200	Biopsy of urethra		T	0166	21.6923	$1,494.08	.	$298.82
53210	Removal of urethra		T	0168	32.6605	$2,249.52	.	$449.91
53215	Removal of urethra		T	0166	21.6923	$1,494.08	.	$298.82
53220	Treatment of urethra lesion		T	0168	32.6605	$2,249.52	.	$449.91
53230	Removal of urethra lesion		T	0168	32.6605	$2,249.52	.	$449.91
53235	Removal of urethra lesion		T	0166	21.6923	$1,494.08	.	$298.82
53240	Surgery for urethra pouch		T	0168	32.6605	$2,249.52	.	$449.91
53250	Removal of urethra gland		T	0166	21.6923	$1,494.08	.	$298.82
53260	Treatment of urethra lesion		T	0166	21.6923	$1,494.08	.	$298.82
53265	Treatment of urethra lesion		T	0166	21.6923	$1,494.08	.	$298.82
53270	Removal of urethra gland		T	0166	21.6923	$1,494.08	.	$298.82
53275	Repair of urethra defect		T	0166	21.6923	$1,494.08	.	$298.82
53400	Revise urethra stage 1		T	0168	32.6605	$2,249.52	.	$449.91
53405	Revise urethra stage 2		T	0168	32.6605	$2,249.52	.	$449.91
53410	Reconstruction of urethra		T	0168	32.6605	$2,249.52	.	$449.91
53415	Reconstruction of urethra		C					
53420	Reconstruct urethra stage 1		T	0168	32.6605	$2,249.52	.	$449.91
53425	Reconstruct urethra stage 2		T	0168	32.6605	$2,249.52	.	$449.91
53430	Reconstruction of urethra		T	0168	32.6605	$2,249.52	.	$449.91
53431	Reconstruct urethra/bladder		T	0168	32.6605	$2,249.52	.	$449.91
53440	Male sling procedure		S	0385	102.4439	$7,055.93	.	$1,411.19
53442	Remove/revise male sling		T	0168	32.6605	$2,249.52	.	$449.91
53444	Insert tandem cuff		S	0385	102.4439	$7,055.93	.	$1,411.19
53445	Insert uro/ves nck sphincter		S	0386	168.7831	$11,625.10	.	$2,325.02
53446	Remove uro sphincter		T	0168	32.6605	$2,249.52	.	$449.91
53447	Remove/replace ur sphincter		S	0386	168.7831	$11,625.10	.	$2,325.02
53448	Remov/replc ur sphinctr comp		C					
53449	Repair uro sphincter		T	0168	32.6605	$2,249.52	.	$449.91
53450	Revision of urethra		T	0168	32.6605	$2,249.52	.	$449.91
53460	Revision of urethra		T	0166	21.6923	$1,494.08	.	$298.82
53500	Urethrlys transvag w/ scope		T	0168	32.6605	$2,249.52	.	$449.91
53502	Repair of urethra injury		T	0166	21.6923	$1,494.08	.	$298.82
53505	Repair of urethra injury		T	0168	32.6605	$2,249.52	.	$449.91
53510	Repair of urethra injury		T	0166	21.6923	$1,494.08	.	$298.82
53515	Repair of urethra injury		T	0168	32.6605	$2,249.52	.	$449.91
53520	Repair of urethra defect		T	0168	32.6605	$2,249.52	.	$449.91

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
53600	Dilate urethra stricture		T	0156	3.2116	$221.20	.	$44.24
53601	Dilate urethra stricture		T	0126	1.1110	$76.52	$16.21	$15.31
53605	Dilate urethra stricture		T	0161	17.5738	$1,210.41	.	$242.09
53620	Dilate urethra stricture		T	0165	20.0886	$1,383.62	.	$276.73
53621	Dilate urethra stricture		T	0164	2.0369	$140.29	.	$28.06
53660	Dilation of urethra		T	0126	1.1110	$76.52	$16.21	$15.31
53661	Dilation of urethra		T	0126	1.1110	$76.52	$16.21	$15.31
53665	Dilation of urethra		T	0166	21.6923	$1,494.08	.	$298.82
53850	Prostatic microwave thermotx		T	0429	46.4709	$3,200.73	.	$640.15
53852	Prostatic rf thermotx		T	0429	46.4709	$3,200.73	.	$640.15
53855	Insert prost urethral stent		T	0164	2.0369	$140.29	.	$28.06
53860	Transurethral rf treatment	NI	T	0165	20.0886	$1,383.62	.	$276.73
53899	Urology surgery procedure		T	0126	1.1110	$76.52	$16.21	$15.31
54000	Slitting of prepuce		T	0166	21.6923	$1,494.08	.	$298.82
54001	Slitting of prepuce		T	0166	21.6923	$1,494.08	.	$298.82
54015	Drain penis lesion		T	0008	20.1996	$1,391.27	.	$278.26
54050	Destruction penis lesion(s)		T	0013	0.9103	$62.70	.	$12.54
54055	Destruction penis lesion(s)		T	0017	21.7969	$1,501.28	.	$300.26
54056	Cryosurgery penis lesion(s)		T	0013	0.9103	$62.70	.	$12.54
54057	Laser surg penis lesion(s)		T	0017	21.7969	$1,501.28	.	$300.26
54060	Excision of penis lesion(s)		T	0017	21.7969	$1,501.28	.	$300.26
54065	Destruction penis lesion(s)		T	0017	21.7969	$1,501.28	.	$300.26
54100	Biopsy of penis		T	0021	18.0784	$1,245.17	.	$249.04
54105	Biopsy of penis		T	0022	23.8986	$1,646.04	$354.45	$329.21
54110	Treatment of penis lesion		T	0181	35.9464	$2,475.84	$620.84	$495.17
54111	Treat penis lesion graft		T	0181	35.9464	$2,475.84	$620.84	$495.17
54112	Treat penis lesion graft		T	0181	35.9464	$2,475.84	$620.84	$495.17
54115	Treatment of penis lesion		T	0008	20.1996	$1,391.27	.	$278.26
54120	Partial removal of penis		T	0181	35.9464	$2,475.84	$620.84	$495.17
54125	Removal of penis		C					
54130	Remove penis & nodes		C					
54135	Remove penis & nodes		C					
54150	Circumcision w/regionl block		T	0183	23.7359	$1,634.83	.	$326.97
54160	Circumcision neonate		T	0183	23.7359	$1,634.83	.	$326.97
54161	Circum 28 days or older		T	0183	23.7359	$1,634.83	.	$326.97
54162	Lysis penil circumic lesion		T	0183	23.7359	$1,634.83	.	$326.97
54163	Repair of circumcision		T	0183	23.7359	$1,634.83	.	$326.97
54164	Frenulolomy of penis		T	0183	23.7359	$1,634.83	.	$326.97
54200	Treatment of penis lesion		T	0164	2.0369	$140.29	.	$28.06

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54205	Treatment of penis lesion		T	0181	35.9464	$2,475.84	$620.84	$495.17
54220	Treatment of penis lesion		T	0164	2.0369	$140.29	.	$28.06
54230	Prepare penis study		N					
54231	Dynamic cavernosometry		T	0165	20.0886	$1,383.62	.	$276.73
54235	Penile injection	CH	T	0156	3.2116	$221.20	.	$44.24
54240	Penis study		T	0126	1.1110	$76.52	$16.21	$15.31
54250	Penis study		T	0164	2.0369	$140.29	.	$28.06
54300	Revision of penis		T	0181	35.9464	$2,475.84	$620.84	$495.17
54304	Revision of penis		T	0181	35.9464	$2,475.84	$620.84	$495.17
54308	Reconstruction of urethra		T	0181	35.9464	$2,475.84	$620.84	$495.17
54312	Reconstruction of urethra		T	0181	35.9464	$2,475.84	$620.84	$495.17
54316	Reconstruction of urethra		T	0181	35.9464	$2,475.84	$620.84	$495.17
54318	Reconstruction of urethra		T	0181	35.9464	$2,475.84	$620.84	$495.17
54322	Reconstruction of urethra		T	0181	35.9464	$2,475.84	$620.84	$495.17
54324	Reconstruction of urethra		T	0181	35.9464	$2,475.84	$620.84	$495.17
54326	Reconstruction of urethra		T	0181	35.9464	$2,475.84	$620.84	$495.17
54328	Revise penis/urethra		T	0181	35.9464	$2,475.84	$620.84	$495.17
54332	Revise penis/urethra		T	0181	35.9464	$2,475.84	$620.84	$495.17
54336	Revise penis/urethra		T	0181	35.9464	$2,475.84	$620.84	$495.17
54340	Secondary urethral surgery		T	0181	35.9464	$2,475.84	$620.84	$495.17
54344	Secondary urethral surgery		T	0181	35.9464	$2,475.84	$620.84	$495.17
54348	Secondary urethral surgery		T	0181	35.9464	$2,475.84	$620.84	$495.17
54352	Reconstruct urethra/penis		T	0181	35.9464	$2,475.84	$620.84	$495.17
54360	Penis plastic surgery		T	0181	35.9464	$2,475.84	$620.84	$495.17
54380	Repair penis		T	0181	35.9464	$2,475.84	$620.84	$495.17
54385	Repair penis		T	0181	35.9464	$2,475.84	$620.84	$495.17
54390	Repair penis and bladder		C					
54400	Insert semi-rigid prosthesis		S	0385	102.4439	$7,055.93	.	$1,411.19
54401	Insert self-contd prosthesis		S	0386	168.7831	$11,625.10	.	$2,325.02
54405	Insert multi-comp penis pros		S	0386	168.7831	$11,625.10	.	$2,325.02
54406	Remove muti-comp penis pros		T	0181	35.9464	$2,475.84	$620.84	$495.17
54408	Repair multi-comp penis pros		T	0181	35.9464	$2,475.84	$620.84	$495.17
54410	Remove/replace penis prosth		S	0386	168.7831	$11,625.10	.	$2,325.02
54411	Remov/replc penis pros comp		C					
54415	Remove self-contd penis pros		T	0181	35.9464	$2,475.84	$620.84	$495.17
54416	Remv/repl penis contain pros		S	0386	168.7831	$11,625.10	.	$2,325.02
54417	Remv/replc penis pros compl		C					
54420	Revision of penis		T	0181	35.9464	$2,475.84	$620.84	$495.17
54430	Revision of penis		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54435	Revision of penis		T	0181	35.9464	$2,475.84	$620.84	$495.17
54440	Repair of penis		T	0181	35.9464	$2,475.84	$620.84	$495.17
54450	Preputial stretching		T	0156	3.2116	$221.20	.	$44.24
54500	Biopsy of testis		T	0037	15.7009	$1,081.42	$228.76	$216.29
54505	Biopsy of testis		T	0183	23.7359	$1,634.83	.	$326.97
54512	Excise lesion testis		T	0183	23.7359	$1,634.83	.	$326.97
54520	Removal of testis		T	0183	23.7359	$1,634.83	.	$326.97
54522	Orchiectomy partial		T	0183	23.7359	$1,634.83	.	$326.97
54530	Removal of testis		T	0154	33.0791	$2,278.36	$464.85	$455.68
54535	Extensive testis surgery		T	0181	35.9464	$2,475.84	$620.84	$495.17
54550	Exploration for testis		T	0154	33.0791	$2,278.36	$464.85	$455.68
54560	Exploration for testis		T	0183	23.7359	$1,634.83	.	$326.97
54600	Reduce testis torsion		T	0183	23.7359	$1,634.83	.	$326.97
54620	Suspension of testis		T	0183	23.7359	$1,634.83	.	$326.97
54640	Suspension of testis		T	0154	33.0791	$2,278.36	$464.85	$455.68
54650	Orchiopexy (Fowler-Stephens)		C					
54660	Revision of testis		T	0183	23.7359	$1,634.83	.	$326.97
54670	Repair testis injury		T	0183	23.7359	$1,634.83	.	$326.97
54680	Relocation of testis(es)		T	0183	23.7359	$1,634.83	.	$326.97
54690	Laparoscopy orchiectomy		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
54692	Laparoscopy orchiopexy		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
54699	Laparoscope proc testis		T	0130	38.6514	$2,662.15	$659.53	$532.43
54700	Drainage of scrotum		T	0183	23.7359	$1,634.83	.	$326.97
54800	Biopsy of epididymis		T	0004	4.5843	$315.75	.	$63.15
54830	Remove epididymis lesion		T	0183	23.7359	$1,634.83	.	$326.97
54840	Remove epididymis lesion		T	0183	23.7359	$1,634.83	.	$326.97
54860	Removal of epididymis		T	0183	23.7359	$1,634.83	.	$326.97
54861	Removal of epididymis		T	0183	23.7359	$1,634.83	.	$326.97
54865	Explore epididymis		T	0183	23.7359	$1,634.83	.	$326.97
54900	Fusion of spermatic ducts		T	0183	23.7359	$1,634.83	.	$326.97
54901	Fusion of spermatic ducts		T	0183	23.7359	$1,634.83	.	$326.97
55000	Drainage of hydrocele		T	0004	4.5843	$315.75	.	$63.15
55040	Removal of hydrocele		T	0154	33.0791	$2,278.36	$464.85	$455.68
55041	Removal of hydroceles		T	0154	33.0791	$2,278.36	$464.85	$455.68
55060	Repair of hydrocele		T	0183	23.7359	$1,634.83	.	$326.97
55100	Drainage of scrotum abscess		T	0007	13.0129	$896.28	.	$179.26
55110	Explore scrotum		T	0183	23.7359	$1,634.83	.	$326.97
55120	Removal of scrotum lesion		T	0183	23.7359	$1,634.83	.	$326.97
55150	Removal of scrotum		T	0183	23.7359	$1,634.83	.	$326.97

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
55175	Revision of scrotum		T	0183	23.7359	$1,634.83	.	$326.97
55180	Revision of scrotum		T	0183	23.7359	$1,634.83	.	$326.97
55200	Incision of sperm duct		T	0183	23.7359	$1,634.83	.	$326.97
55250	Removal of sperm duct(s)		T	0183	23.7359	$1,634.83	.	$326.97
55300	Prepare sperm duct x-ray		N					
55400	Repair of sperm duct		T	0183	23.7359	$1,634.83	.	$326.97
55450	Ligation of sperm duct		T	0183	23.7359	$1,634.83	.	$326.97
55500	Removal of hydrocele		T	0183	23.7359	$1,634.83	.	$326.97
55520	Removal of sperm cord lesion		T	0183	23.7359	$1,634.83	.	$326.97
55530	Revise spermatic cord veins		T	0183	23.7359	$1,634.83	.	$326.97
55535	Revise spermatic cord veins		T	0154	33.0791	$2,278.36	$464.85	$455.68
55540	Revise hernia & sperm veins		T	0154	33.0791	$2,278.36	$464.85	$455.68
55550	Laparo ligate spermatic vein		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
55559	Laparo proc spermatic cord		T	0130	38.6514	$2,662.15	$659.53	$532.43
55600	Incise sperm duct pouch		T	0183	23.7359	$1,634.83	.	$326.97
55605	Incise sperm duct pouch		C					
55650	Remove sperm duct pouch		C					
55680	Remove sperm pouch lesion		T	0183	23.7359	$1,634.83	.	$326.97
55700	Biopsy of prostate		T	0184	13.0286	$897.36	.	$179.48
55705	Biopsy of prostate		T	0184	13.0286	$897.36	.	$179.48
55706	Prostate saturation sampling		T	0184	13.0286	$897.36	.	$179.48
55720	Drainage of prostate abscess		T	0162	26.3334	$1,813.74	.	$362.75
55725	Drainage of prostate abscess		T	0162	26.3334	$1,813.74	.	$362.75
55801	Removal of prostate		C					
55810	Extensive prostate surgery		C					
55812	Extensive prostate surgery		C					
55815	Extensive prostate surgery		C					
55821	Removal of prostate		C					
55831	Removal of prostate		C					
55840	Extensive prostate surgery		C					
55842	Extensive prostate surgery		C					
55845	Extensive prostate surgery		C					
55860	Surgical exposure prostate		T	0165	20.0886	$1,383.62	.	$276.73
55862	Extensive prostate surgery		C					
55865	Extensive prostate surgery		C					
55866	Laparo radical prostatectomy		C					
55870	Electroejaculation		T	0189	3.6204	$249.36	.	$49.88
55873	Cryoablate prostate		T	0674	116.4217	$8,018.66	.	$1,603.74
55875	Transperi needle place pros		Q3	0163	37.3582	$2,573.08	.	$514.62

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
55876	Place rt device/marker pros		X	0310	13.4552	$926.74	$325.27	$185.35
55899	Genital surgery procedure		T	0126	1.1110	$76.52	$16.21	$15.31
55920	Place needles pelvic for rt		T	0153	26.4829	$1,824.04	$375.24	$364.81
55970	Sex transformation m to f		E					
55980	Sex transformation f to m		E					
56405	I & D of vulva/perineum		T	0188	1.6350	$112.61	.	$22.53
56420	Drainage of gland abscess		T	0188	1.6350	$112.61	.	$22.53
56440	Surgery for vulva lesion		T	0193	20.6779	$1,424.21	.	$284.85
56441	Lysis of labial lesion(s)		T	0193	20.6779	$1,424.21	.	$284.85
56442	Hymenotomy		T	0193	20.6779	$1,424.21	.	$284.85
56501	Destroy vulva lesions sim		T	0017	21.7969	$1,501.28	.	$300.26
56515	Destroy vulva lesion/s compl		T	0017	21.7969	$1,501.28	.	$300.26
56605	Biopsy of vulva/perineum		T	0189	3.6204	$249.36	.	$49.88
56606	Biopsy of vulva/perineum		T	0188	1.6350	$112.61	.	$22.53
56620	Partial removal of vulva		T	0193	20.6779	$1,424.21	.	$284.85
56625	Complete removal of vulva		T	0193	20.6779	$1,424.21	.	$284.85
56630	Extensive vulva surgery		C					
56631	Extensive vulva surgery		C					
56632	Extensive vulva surgery		C					
56633	Extensive vulva surgery		C					
56634	Extensive vulva surgery		C					
56637	Extensive vulva surgery		C					
56640	Extensive vulva surgery		C					
56700	Partial removal of hymen		T	0193	20.6779	$1,424.21	.	$284.85
56740	Remove vagina gland lesion		T	0193	20.6779	$1,424.21	.	$284.85
56800	Repair of vagina		T	0193	20.6779	$1,424.21	.	$284.85
56805	Repair clitoris		T	0193	20.6779	$1,424.21	.	$284.85
56810	Repair of perineum		T	0193	20.6779	$1,424.21	.	$284.85
56820	Exam of vulva w/scope		T	0188	1.6350	$112.61	.	$22.53
56821	Exam/biopsy of vulva w/scope		T	0188	1.6350	$112.61	.	$22.53
57000	Exploration of vagina		T	0193	20.6779	$1,424.21	.	$284.85
57010	Drainage of pelvic abscess		T	0193	20.6779	$1,424.21	.	$284.85
57020	Drainage of pelvic fluid		T	0192	6.5660	$452.24	.	$90.45
57022	I & d vaginal hematoma pp		T	0007	13.0129	$896.28	.	$179.26
57023	I & d vag hematoma non-ob		T	0008	20.1996	$1,391.27	.	$278.26
57061	Destroy vag lesions simple		T	0193	20.6779	$1,424.21	.	$284.85
57065	Destroy vag lesions complex		T	0193	20.6779	$1,424.21	.	$284.85
57100	Biopsy of vagina		T	0192	6.5660	$452.24	.	$90.45
57105	Biopsy of vagina		T	0193	20.6779	$1,424.21	.	$284.85

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57106	Remove vagina wall partial		T	0193	20.6779	$1,424.21	.	$284.85
57107	Remove vagina tissue part		T	0195	35.6739	$2,457.08	.	$491.42
57109	Vaginectomy partial w/nodes		T	0195	35.6739	$2,457.08	.	$491.42
57110	Remove vagina wall complete		C					
57111	Remove vagina tissue compl		C					
57112	Vaginectomy w/nodes compl		C					
57120	Closure of vagina		T	0195	35.6739	$2,457.08	.	$491.42
57130	Remove vagina lesion		T	0193	20.6779	$1,424.21	.	$284.85
57135	Remove vagina lesion		T	0193	20.6779	$1,424.21	.	$284.85
57150	Treat vagina infection		T	0188	1.6350	$112.61	.	$22.53
57155	Insert uteri tandems/ovoids		T	0192	6.5660	$452.24	.	$90.45
57156	Ins vag brachytx device	NI	T	0189	3.6204	$249.36	.	$49.88
57160	Insert pessary/other device		T	0188	1.6350	$112.61	.	$22.53
57170	Fitting of diaphragm/cap		T	0191	0.1446	$9.96	$2.08	$2.00
57180	Treat vaginal bleeding		T	0188	1.6350	$112.61	.	$22.53
57200	Repair of vagina		T	0193	20.6779	$1,424.21	.	$284.85
57210	Repair vagina/perineum		T	0193	20.6779	$1,424.21	.	$284.85
57220	Revision of urethra		T	0202	45.3938	$3,126.54	$981.50	$625.31
57230	Repair of urethral lesion		T	0195	35.6739	$2,457.08	.	$491.42
57240	Repair bladder & vagina		T	0195	35.6739	$2,457.08	.	$491.42
57250	Repair rectum & vagina		T	0195	35.6739	$2,457.08	.	$491.42
57260	Repair of vagina		T	0195	35.6739	$2,457.08	.	$491.42
57265	Extensive repair of vagina		T	0202	45.3938	$3,126.54	$981.50	$625.31
57267	Insert mesh/pelvic flr addon		T	0195	35.6739	$2,457.08	.	$491.42
57268	Repair of bowel bulge		T	0195	35.6739	$2,457.08	.	$491.42
57270	Repair of bowel pouch		C					
57280	Suspension of vagina		C					
57282	Colpopexy extraperitoneal		T	0202	45.3938	$3,126.54	$981.50	$625.31
57283	Colpopexy intraperitoneal		T	0202	45.3938	$3,126.54	$981.50	$625.31
57284	Repair paravag defect open		T	0202	45.3938	$3,126.54	$981.50	$625.31
57285	Repair paravag defect vag		T	0202	45.3938	$3,126.54	$981.50	$625.31
57287	Revise/remove sling repair		T	0195	35.6739	$2,457.08	.	$491.42
57288	Repair bladder defect		T	0202	45.3938	$3,126.54	$981.50	$625.31
57289	Repair bladder & vagina		T	0195	35.6739	$2,457.08	.	$491.42
57291	Construction of vagina		T	0195	35.6739	$2,457.08	.	$491.42
57292	Construct vagina with graft		T	0195	35.6739	$2,457.08	.	$491.42
57295	Revise vag graft via vagina		T	0193	20.6779	$1,424.21	.	$284.85
57296	Revise vag graft open abd		C					
57300	Repair rectum-vagina fistula		T	0195	35.6739	$2,457.08	.	$491.42

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57305	Repair rectum-vagina fistula		C					
57307	Fistula repair & colostomy		C					
57308	Fistula repair transperine		C					
57310	Repair urethrovaginal lesion		T	0202	45.3938	$3,126.54	$981.50	$625.31
57311	Repair urethrovaginal lesion		C					
57320	Repair bladder-vagina lesion		T	0195	35.6739	$2,457.08	.	$491.42
57330	Repair bladder-vagina lesion		T	0195	35.6739	$2,457.08	.	$491.42
57335	Repair vagina		T	0195	35.6739	$2,457.08	.	$491.42
57400	Dilation of vagina		T	0193	20.6779	$1,424.21	.	$284.85
57410	Pelvic examination		T	0193	20.6779	$1,424.21	.	$284.85
57415	Remove vaginal foreign body		T	0193	20.6779	$1,424.21	.	$284.85
57420	Exam of vagina w/scope		T	0189	3.6204	$249.36	.	$49.88
57421	Exam/biopsy of vag w/scope		T	0189	3.6204	$249.36	.	$49.88
57423	Repair paravag defect lap		T	0202	45.3938	$3,126.54	$981.50	$625.31
57425	Laparoscopy surg colpopexy		T	0130	38.6514	$2,662.15	$659.53	$532.43
57426	Revise prosth vag graft lap		T	0193	20.6779	$1,424.21	.	$284.85
57452	Exam of cervix w/scope		T	0188	1.6350	$112.61	.	$22.53
57454	Bx/curett of cervix w/scope		T	0189	3.6204	$249.36	.	$49.88
57455	Biopsy of cervix w/scope		T	0189	3.6204	$249.36	.	$49.88
57456	Endocerv curettage w/scope		T	0189	3.6204	$249.36	.	$49.88
57460	Bx of cervix w/scope leep		T	0193	20.6779	$1,424.21	.	$284.85
57461	Conz of cervix w/scope leep		T	0193	20.6779	$1,424.21	.	$284.85
57500	Biopsy of cervix		T	0192	6.5660	$452.24	.	$90.45
57505	Endocervical curettage		T	0192	6.5660	$452.24	.	$90.45
57510	Cauterization of cervix		T	0193	20.6779	$1,424.21	.	$284.85
57511	Cryocautery of cervix		T	0188	1.6350	$112.61	.	$22.53
57513	Laser surgery of cervix		T	0193	20.6779	$1,424.21	.	$284.85
57520	Conization of cervix		T	0193	20.6779	$1,424.21	.	$284.85
57522	Conization of cervix		T	0193	20.6779	$1,424.21	.	$284.85
57530	Removal of cervix		T	0195	35.6739	$2,457.08	.	$491.42
57531	Removal of cervix radical		C					
57540	Removal of residual cervix		C					
57545	Remove cervix/repair pelvis		C					
57550	Removal of residual cervix		T	0195	35.6739	$2,457.08	.	$491.42
57555	Remove cervix/repair vagina		T	0195	35.6739	$2,457.08	.	$491.42
57556	Remove cervix repair bowel		T	0202	45.3938	$3,126.54	$981.50	$625.31
57558	D&c of cervical stump		T	0193	20.6779	$1,424.21	.	$284.85
57700	Revision of cervix		T	0193	20.6779	$1,424.21	.	$284.85
57720	Revision of cervix		T	0193	20.6779	$1,424.21	.	$284.85

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57800	Dilation of cervical canal		T	0193	20.6779	$1,424.21	.	$284.85
58100	Biopsy of uterus lining		T	0188	1.6350	$112.61	.	$22.53
58110	Bx done w/colposcopy add-on		N					
58120	Dilation and curettage		T	0193	20.6779	$1,424.21	.	$284.85
58140	Myomectomy abdom method		C					
58145	Myomectomy vag method		T	0195	35.6739	$2,457.08	.	$491.42
58146	Myomectomy abdom complex		C					
58150	Total hysterectomy		C					
58152	Total hysterectomy		C					
58180	Partial hysterectomy		C					
58200	Extensive hysterectomy		C					
58210	Extensive hysterectomy		C					
58240	Removal of pelvis contents		C					
58260	Vaginal hysterectomy		T	0195	35.6739	$2,457.08	.	$491.42
58262	Vag hyst including t/o		T	0195	35.6739	$2,457.08	.	$491.42
58263	Vag hyst w/t/o & vag repair		T	0195	35.6739	$2,457.08	.	$491.42
58267	Vag hyst w/urinary repair		C					
58270	Vag hyst w/enterocele repair		T	0195	35.6739	$2,457.08	.	$491.42
58275	Hysterectomy/revise vagina		C					
58280	Hysterectomy/revise vagina		C					
58285	Extensive hysterectomy		C					
58290	Vag hyst complex		T	0202	45.3938	$3,126.54	$981.50	$625.31
58291	Vag hyst incl t/o complex		T	0202	45.3938	$3,126.54	$981.50	$625.31
58292	Vag hyst t/o & repair compl		T	0202	45.3938	$3,126.54	$981.50	$625.31
58293	Vag hyst w/uro repair compl		C					
58294	Vag hyst w/enterocele compl		T	0202	45.3938	$3,126.54	$981.50	$625.31
58300	Insert intrauterine device		E					
58301	Remove intrauterine device		T	0188	1.6350	$112.61	.	$22.53
58321	Artificial insemination		T	0189	3.6204	$249.36	.	$49.88
58322	Artificial insemination		T	0189	3.6204	$249.36	.	$49.88
58323	Sperm washing		T	0189	3.6204	$249.36	.	$49.88
58340	Catheter for hysterography		N					
58345	Reopen fallopian tube		T	0193	20.6779	$1,424.21	.	$284.85
58346	Insert heyman uteri capsule		T	0193	20.6779	$1,424.21	.	$284.85
58350	Reopen fallopian tube		T	0195	35.6739	$2,457.08	.	$491.42
58353	Endometr ablate thermal		T	0195	35.6739	$2,457.08	.	$491.42
58356	Endometrial cryoablation		T	0202	45.3938	$3,126.54	$981.50	$625.31
58400	Suspension of uterus		C					
58410	Suspension of uterus		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58520	Repair of ruptured uterus		C					
58540	Revision of uterus		C					
58541	Lsh uterus 250 g or less		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
58542	Lsh w/t/o ut 250 g or less		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
58543	Lsh uterus above 250 g		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
58544	Lsh w/t/o uterus above 250 g		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
58545	Laparoscopic myomectomy		T	0130	38.6514	$2,662.15	$659.53	$532.43
58546	Laparo-myomectomy complex		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58548	Lap radical hyst		C					
58550	Laparo-asst vag hysterectomy		T	0132	71.0980	$4,896.95	$1,236.99	$979.39
58552	Laparo-vag hyst incl t/o		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58553	Laparo-vag hyst complex		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58554	Laparo-vag hyst w/t/o compl		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58555	Hysteroscopy dx sep proc		T	0190	23.0829	$1,589.86	$424.28	$317.98
58558	Hysteroscopy biopsy		T	0190	23.0829	$1,589.86	$424.28	$317.98
58559	Hysteroscopy lysis		T	0190	23.0829	$1,589.86	$424.28	$317.98
58560	Hysteroscopy resect septum		T	0387	38.4941	$2,651.32	$655.55	$530.27
58561	Hysteroscopy remove myoma		T	0387	38.4941	$2,651.32	$655.55	$530.27
58562	Hysteroscopy remove fb		T	0190	23.0829	$1,589.86	$424.28	$317.98
58563	Hysteroscopy ablation		T	0387	38.4941	$2,651.32	$655.55	$530.27
58565	Hysteroscopy sterilization		T	0202	45.3938	$3,126.54	$981.50	$625.31
58570	Tlh uterus 250 g or less		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58571	Tlh w/t/o 250 g or less		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58572	Tlh uterus over 250 g		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58573	Tlh w/t/o uterus over 250 g		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58578	Laparo proc uterus		T	0130	38.6514	$2,662.15	$659.53	$532.43
58579	Hysteroscope procedure		T	0190	23.0829	$1,589.86	$424.28	$317.98
58600	Division of fallopian tube		T	0195	35.6739	$2,457.08	.	$491.42
58605	Division of fallopian tube		C					
58611	Ligate oviduct(s) add-on		C					
58615	Occlude fallopian tube(s)		T	0193	20.6779	$1,424.21	.	$284.85
58660	Laparoscopy lysis		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58661	Laparoscopy remove adnexa		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58662	Laparoscopy excise lesions		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58670	Laparoscopy tubal cautery		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58671	Laparoscopy tubal block		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58672	Laparoscopy fimbrioplasty		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58673	Laparoscopy salpingostomy		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
58679	Laparo proc oviduct-ovary		T	0130	38.6514	$2,662.15	$659.53	$532.43

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58700	Removal of fallopian tube		C					
58720	Removal of ovary/tube(s)		C					
58740	Adhesiolysis tube ovary		C					
58750	Repair oviduct		C					
58752	Revise ovarian tube(s)		C					
58760	Fimbrioplasty		C					
58770	Create new tubal opening		T	0195	35.6739	$2,457.08	.	$491.42
58800	Drainage of ovarian cyst(s)		T	0193	20.6779	$1,424.21	.	$284.85
58805	Drainage of ovarian cyst(s)		T	0195	35.6739	$2,457.08	.	$491.42
58820	Drain ovary abscess open		T	0195	35.6739	$2,457.08	.	$491.42
58822	Drain ovary abscess percut		C					
58823	Drain pelvic abscess percut		T	0193	20.6779	$1,424.21	.	$284.85
58825	Transposition ovary(s)		C					
58900	Biopsy of ovary(s)		T	0193	20.6779	$1,424.21	.	$284.85
58920	Partial removal of ovary(s)		T	0195	35.6739	$2,457.08	.	$491.42
58925	Removal of ovarian cyst(s)		T	0195	35.6739	$2,457.08	.	$491.42
58940	Removal of ovary(s)		C					
58943	Removal of ovary(s)		C					
58950	Resect ovarian malignancy		C					
58951	Resect ovarian malignancy		C					
58952	Resect ovarian malignancy		C					
58953	Tah rad dissect for debulk		C					
58954	Tah rad debulk/lymph remove		C					
58956	Bso omentectomy w/tah		C					
58957	Resect recurrent gyn mal		C					
58958	Resect recur gyn mal w/lym		C					
58960	Exploration of abdomen		C					
58970	Retrieval of oocyte		T	0189	3.6204	$249.36	.	$49.88
58974	Transfer of embryo		T	0189	3.6204	$249.36	.	$49.88
58976	Transfer of embryo		T	0189	3.6204	$249.36	.	$49.88
58999	Genital surgery procedure		T	0191	0.1446	$9.96	$2.08	$2.00
59000	Amniocentesis diagnostic		T	0189	3.6204	$249.36	.	$49.88
59001	Amniocentesis therapeutic		T	0192	6.5660	$452.24	.	$90.45
59012	Fetal cord puncture prenatal		T	0189	3.6204	$249.36	.	$49.88
59015	Chorion biopsy		T	0189	3.6204	$249.36	.	$49.88
59020	Fetal contract stress test		T	0188	1.6350	$112.61	.	$22.53
59025	Fetal non-stress test		T	0188	1.6350	$112.61	.	$22.53
59030	Fetal scalp blood sample		T	0189	3.6204	$249.36	.	$49.88
59050	Fetal monitor w/report		M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59051	Fetal monitor/interpret only		B					
59070	Transabdom amnioinfus w/us		T	0188	1.6350	$112.61	.	$22.53
59072	Umbilical cord occlud w/us		T	0189	3.6204	$249.36	.	$49.88
59074	Fetal fluid drainage w/us		T	0189	3.6204	$249.36	.	$49.88
59076	Fetal shunt placement w/us		T	0189	3.6204	$249.36	.	$49.88
59100	Remove uterus lesion		T	0195	35.6739	$2,457.08	.	$491.42
59120	Treat ectopic pregnancy		C					
59121	Treat ectopic pregnancy		C					
59130	Treat ectopic pregnancy		C					
59135	Treat ectopic pregnancy		C					
59136	Treat ectopic pregnancy		C					
59140	Treat ectopic pregnancy		C					
59150	Treat ectopic pregnancy		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
59151	Treat ectopic pregnancy		T	0131	47.8453	$3,295.39	$1,001.89	$659.08
59160	D & c after delivery		T	0193	20.6779	$1,424.21	.	$284.85
59200	Insert cervical dilator		T	0188	1.6350	$112.61	.	$22.53
59300	Episiotomy or vaginal repair		T	0193	20.6779	$1,424.21	.	$284.85
59320	Revision of cervix		T	0193	20.6779	$1,424.21	.	$284.85
59325	Revision of cervix		C					
59350	Repair of uterus		C					
59400	Obstetrical care		B					
59409	Obstetrical care		T	0193	20.6779	$1,424.21	.	$284.85
59410	Obstetrical care		B					
59412	Antepartum manipulation		T	0193	20.6779	$1,424.21	.	$284.85
59414	Deliver placenta		T	0193	20.6779	$1,424.21	.	$284.85
59425	Antepartum care only		B					
59426	Antepartum care only		B					
59430	Care after delivery		B					
59510	Cesarean delivery		B					
59514	Cesarean delivery only		C					
59515	Cesarean delivery		B					
59525	Remove uterus after cesarean		C					
59610	Vbac delivery		B					
59612	Vbac delivery only		T	0193	20.6779	$1,424.21	.	$284.85
59614	Vbac care after delivery		B					
59618	Attempted vbac delivery		B					
59620	Attempted vbac delivery only		C					
59622	Attempted vbac after care		B					
59812	Treatment of miscarriage		T	0193	20.6779	$1,424.21	.	$284.85

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59820	Care of miscarriage		T	0193	20.6779	$1,424.21	.	$284.85
59821	Treatment of miscarriage		T	0193	20.6779	$1,424.21	.	$284.85
59830	Treat uterus infection		C					
59840	Abortion		T	0193	20.6779	$1,424.21	.	$284.85
59841	Abortion		T	0193	20.6779	$1,424.21	.	$284.85
59850	Abortion		C					
59851	Abortion		C					
59852	Abortion		C					
59855	Abortion		C					
59856	Abortion		C					
59857	Abortion		C					
59866	Abortion (mpr)		T	0189	3.6204	$249.36	.	$49.88
59870	Evacuate mole of uterus		T	0193	20.6779	$1,424.21	.	$284.85
59871	Remove cerclage suture		T	0193	20.6779	$1,424.21	.	$284.85
59897	Fetal invas px w/us		T	0191	0.1446	$9.96	$2.08	$2.00
59898	Laparo proc ob care/deliver		T	0130	38.6514	$2,662.15	$659.53	$532.43
59899	Maternity care procedure		T	0191	0.1446	$9.96	$2.08	$2.00
60000	Drain thyroid/tongue cyst		T	0252	7.9194	$545.46	$109.16	$109.10
60100	Biopsy of thyroid		T	0004	4.5843	$315.75	.	$63.15
60200	Remove thyroid lesion		T	0114	50.7814	$3,497.62	.	$699.53
60210	Partial thyroid excision		T	0114	50.7814	$3,497.62	.	$699.53
60212	Partial thyroid excision		T	0114	50.7814	$3,497.62	.	$699.53
60220	Partial removal of thyroid		T	0114	50.7814	$3,497.62	.	$699.53
60225	Partial removal of thyroid		T	0114	50.7814	$3,497.62	.	$699.53
60240	Removal of thyroid		T	0114	50.7814	$3,497.62	.	$699.53
60252	Removal of thyroid		T	0256	44.6899	$3,078.06	.	$615.62
60254	Extensive thyroid surgery		C					
60260	Repeat thyroid surgery		T	0256	44.6899	$3,078.06	.	$615.62
60270	Removal of thyroid		C					
60271	Removal of thyroid		T	0256	44.6899	$3,078.06	.	$615.62
60280	Remove thyroid duct lesion		T	0114	50.7814	$3,497.62	.	$699.53
60281	Remove thyroid duct lesion		T	0114	50.7814	$3,497.62	.	$699.53
60300	Aspir/inj thyroid cyst		T	0004	4.5843	$315.75	.	$63.15
60500	Explore parathyroid glands		T	0256	44.6899	$3,078.06	.	$615.62
60502	Re-explore parathyroids		T	0256	44.6899	$3,078.06	.	$615.62
60505	Explore parathyroid glands		C					
60512	Autotransplant parathyroid		T	0022	23.8986	$1,646.04	$354.45	$329.21
60520	Removal of thymus gland		T	0256	44.6899	$3,078.06	.	$615.62
60521	Removal of thymus gland		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
60522	Removal of thymus gland		C					
60540	Explore adrenal gland		C					
60545	Explore adrenal gland		C					
60600	Remove carotid body lesion		C					
60605	Remove carotid body lesion		C					
60650	Laparoscopy adrenalectomy		C					
60659	Laparo proc endocrine		T	0130	38.6514	$2,662.15	$659.53	$532.43
60699	Endocrine surgery procedure		T	0114	50.7814	$3,497.62	.	$699.53
61000	Remove cranial cavity fluid		T	0207	7.5886	$522.67	.	$104.54
61001	Remove cranial cavity fluid		T	0207	7.5886	$522.67	.	$104.54
61020	Remove brain cavity fluid		T	0207	7.5886	$522.67	.	$104.54
61026	Injection into brain canal		T	0207	7.5886	$522.67	.	$104.54
61050	Remove brain canal fluid		T	0207	7.5886	$522.67	.	$104.54
61055	Injection into brain canal		T	0207	7.5886	$522.67	.	$104.54
61070	Brain canal shunt procedure		T	0121	6.3298	$435.97	.	$87.20
61105	Twist drill hole		C					
61107	Drill skull for implantation		C					
61108	Drill skull for drainage		C					
61120	Burr hole for puncture		C					
61140	Pierce skull for biopsy		C					
61150	Pierce skull for drainage		C					
61151	Pierce skull for drainage		C					
61154	Pierce skull & remove clot		C					
61156	Pierce skull for drainage		C					
61210	Pierce skull implant device		C					
61215	Insert brain-fluid device		T	0224	41.9167	$2,887.05	.	$577.41
61250	Pierce skull & explore		C					
61253	Pierce skull & explore		C					
61304	Open skull for exploration		C					
61305	Open skull for exploration		C					
61312	Open skull for drainage		C					
61313	Open skull for drainage		C					
61314	Open skull for drainage		C					
61315	Open skull for drainage		C					
61316	Implt cran bone flap to abdo		C					
61320	Open skull for drainage		C					
61321	Open skull for drainage		C					
61322	Decompressive craniotomy		C					
61323	Decompressive lobectomy		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61330	Decompress eye socket		T	0256	44.6899	$3,078.06	.	$615.62
61332	Explore/biopsy eye socket		C					
61333	Explore orbit/remove lesion		C					
61334	Explore orbit/remove object		T	0256	44.6899	$3,078.06	.	$615.62
61340	Subtemporal decompression		C					
61343	Incise skull (press relief)		C					
61345	Relieve cranial pressure		C					
61440	Incise skull for surgery		C					
61450	Incise skull for surgery		C					
61458	Incise skull for brain wound		C					
61460	Incise skull for surgery		C					
61470	Incise skull for surgery		C					
61480	Incise skull for surgery		C					
61490	Incise skull for surgery		C					
61500	Removal of skull lesion		C					
61501	Remove infected skull bone		C					
61510	Removal of brain lesion		C					
61512	Remove brain lining lesion		C					
61514	Removal of brain abscess		C					
61516	Removal of brain lesion		C					
61517	Implt brain chemotx add-on		C					
61518	Removal of brain lesion		C					
61519	Remove brain lining lesion		C					
61520	Removal of brain lesion		C					
61521	Removal of brain lesion		C					
61522	Removal of brain abscess		C					
61524	Removal of brain lesion		C					
61526	Removal of brain lesion		C					
61530	Removal of brain lesion		C					
61531	Implant brain electrodes		C					
61533	Implant brain electrodes		C					
61534	Removal of brain lesion		C					
61535	Remove brain electrodes		C					
61536	Removal of brain lesion		C					
61537	Removal of brain tissue		C					
61538	Removal of brain tissue		C					
61539	Removal of brain tissue		C					
61540	Removal of brain tissue		C					
61541	Incision of brain tissue		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61542	Removal of brain tissue		C					
61543	Removal of brain tissue		C					
61544	Remove & treat brain lesion		C					
61545	Excision of brain tumor		C					
61546	Removal of pituitary gland		C					
61548	Removal of pituitary gland		C					
61550	Release of skull seams		C					
61552	Release of skull seams		C					
61556	Incise skull/sutures		C					
61557	Incise skull/sutures		C					
61558	Excision of skull/sutures		C					
61559	Excision of skull/sutures		C					
61563	Excision of skull tumor		C					
61564	Excision of skull tumor		C					
61566	Removal of brain tissue		C					
61567	Incision of brain tissue		C					
61570	Remove foreign body brain		C					
61571	Incise skull for brain wound		C					
61575	Skull base/brainstem surgery		C					
61576	Skull base/brainstem surgery		C					
61580	Craniofacial approach skull		C					
61581	Craniofacial approach skull		C					
61582	Craniofacial approach skull		C					
61583	Craniofacial approach skull		C					
61584	Orbitocranial approach/skull		C					
61585	Orbitocranial approach/skull		C					
61586	Resect nasopharynx skull		C					
61590	Infratemporal approach/skull		C					
61591	Infratemporal approach/skull		C					
61592	Orbitocranial approach/skull		C					
61595	Transtemporal approach/skull		C					
61596	Transcochlear approach/skull		C					
61597	Transcondylar approach/skull		C					
61598	Transpetrosal approach/skull		C					
61600	Resect/excise cranial lesion		C					
61601	Resect/excise cranial lesion		C					
61605	Resect/excise cranial lesion		C					
61606	Resect/excise cranial lesion		C					
61607	Resect/excise cranial lesion		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61608	Resect/excise cranial lesion		C					
61609	Transect artery sinus		C					
61610	Transect artery sinus		C					
61611	Transect artery sinus		C					
61612	Transect artery sinus		C					
61613	Remove aneurysm sinus		C					
61615	Resect/excise lesion skull		C					
61616	Resect/excise lesion skull		C					
61618	Repair dura		C					
61619	Repair dura		C					
61623	Endovasc tempory vessel occl		T	0082	92.7252	$6,386.54	.	$1,277.31
61624	Transcath occlusion cns		C					
61626	Transcath occlusion non-cns		T	0082	92.7252	$6,386.54	.	$1,277.31
61630	Intracranial angioplasty		C					
61635	Intracran angioplsty w/stent		C					
61640	Dilate ic vasospasm init		E					
61641	Dilate ic vasospasm add-on		E					
61642	Dilate ic vasospasm add-on		E					
61680	Intracranial vessel surgery		C					
61682	Intracranial vessel surgery		C					
61684	Intracranial vessel surgery		C					
61686	Intracranial vessel surgery		C					
61690	Intracranial vessel surgery		C					
61692	Intracranial vessel surgery		C					
61697	Brain aneurysm repr complx		C					
61698	Brain aneurysm repr complx		C					
61700	Brain aneurysm repr simple		C					
61702	Inner skull vessel surgery		C					
61703	Clamp neck artery		C					
61705	Revise circulation to head		C					
61708	Revise circulation to head		C					
61710	Revise circulation to head		C					
61711	Fusion of skull arteries		C					
61720	Incise skull/brain surgery		T	0221	37.2747	$2,567.33	.	$513.47
61735	Incise skull/brain surgery		C					
61750	Incise skull/brain biopsy		C					
61751	Brain biopsy w/ct/mr guide		C					
61760	Implant brain electrodes		C					
61770	Incise skull for treatment		T	0221	37.2747	$2,567.33	.	$513.47

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61781	Scan proc cranial intra	NI	N					
61782	Scan proc cranial extra	NI	N					
61783	Scan proc spinal	NI	N					
61790	Treat trigeminal nerve		T	0220	19.1325	$1,317.77	.	$263.56
61791	Treat trigeminal tract		T	0203	12.7951	$881.28	.	$176.26
61795	Brain surgery using computer	CH	D					
61796	Srs cranial lesion simple		B					
61797	Srs cran les simple addl		B					
61798	Srs cranial lesion complex		B					
61799	Srs cran les complex addl		B					
61800	Apply srs headframe add-on		B					
61850	Implant neuroelectrodes		C					
61860	Implant neuroelectrodes		C					
61863	Implant neuroelectrode		C					
61864	Implant neuroelectrde addl		C					
61867	Implant neuroelectrode		C					
61868	Implant neuroelectrde addl		C					
61870	Implant neuroelectrodes		C					
61875	Implant neuroelectrodes		C					
61880	Revise/remove neuroelectrode		T	0687	21.7224	$1,496.15	$397.37	$299.23
61885	Insrt/redo neurostim 1 array		S	0039	214.0597	$14,743.58	.	$2,948.72
61886	Implant neurostim arrays		S	0315	273.6914	$18,850.77	.	$3,770.16
61888	Revise/remove neuroreceiver		T	0688	29.0860	$2,003.33	$768.94	$400.67
62000	Treat skull fracture		T	0254	25.6472	$1,766.48	.	$353.30
62005	Treat skull fracture		C					
62010	Treatment of head injury		C					
62100	Repair brain fluid leakage		C					
62115	Reduction of skull defect		C					
62116	Reduction of skull defect		C					
62117	Reduction of skull defect		C					
62120	Repair skull cavity lesion		C					
62121	Incise skull repair		C					
62140	Repair of skull defect		C					
62141	Repair of skull defect		C					
62142	Remove skull plate/flap		C					
62143	Replace skull plate/flap		C					
62145	Repair of skull & brain		C					
62146	Repair of skull with graft		C					
62147	Repair of skull with graft		C					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62148	Retr bone flap to fix skull		C					
62160	Neuroendoscopy add-on		N					
62161	Dissect brain w/scope		C					
62162	Remove colloid cyst w/scope		C					
62163	Neuroendoscopy w/fb removal		C					
62164	Remove brain tumor w/scope		C					
62165	Remove pituit tumor w/scope		C					
62180	Establish brain cavity shunt		C					
62190	Establish brain cavity shunt		C					
62192	Establish brain cavity shunt		C					
62194	Replace/irrigate catheter		T	0207	7.5886	$522.67	.	$104.54
62200	Establish brain cavity shunt		C					
62201	Brain cavity shunt w/scope		C					
62220	Establish brain cavity shunt		C					
62223	Establish brain cavity shunt		C					
62225	Replace/irrigate catheter		T	0427	16.3172	$1,123.86	.	$224.78
62230	Replace/revise brain shunt		T	0224	41.9167	$2,887.05	.	$577.41
62252	Csf shunt reprogram		S	0691	2.4221	$166.82	.	$33.37
62256	Remove brain cavity shunt		C					
62258	Replace brain cavity shunt		C					
62263	Epidural lysis mult sessions		T	0207	7.5886	$522.67	.	$104.54
62264	Epidural lysis on single day		T	0203	12.7951	$881.28	.	$176.26
62267	Interdiscal perq aspir dx		T	0004	4.5843	$315.75	.	$63.15
62268	Drain spinal cord cyst		T	0207	7.5886	$522.67	.	$104.54
62269	Needle biopsy spinal cord		T	0685	9.7353	$670.53	.	$134.11
62270	Spinal fluid tap diagnostic		T	0206	3.8823	$267.40	.	$53.48
62272	Drain cerebro spinal fluid		T	0206	3.8823	$267.40	.	$53.48
62273	Inject epidural patch	CH	T	0207	7.5886	$522.67	.	$104.54
62280	Treat spinal cord lesion		T	0207	7.5886	$522.67	.	$104.54
62281	Treat spinal cord lesion		T	0207	7.5886	$522.67	.	$104.54
62282	Treat spinal canal lesion		T	0207	7.5886	$522.67	.	$104.54
62284	Injection for myelogram		N					
62287	Percutaneous diskectomy		T	0221	37.2747	$2,567.33	.	$513.47
62290	Inject for spine disk x-ray		N					
62291	Inject for spine disk x-ray		N					
62292	Injection into disk lesion		T	0207	7.5886	$522.67	.	$104.54
62294	Injection into spinal artery		T	0207	7.5886	$522.67	.	$104.54
62310	Inject spine c/t		T	0207	7.5886	$522.67	.	$104.54
62311	Inject spine l/s (cd)		T	0207	7.5886	$522.67	.	$104.54

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62318	Inject spine w/cath c/t		T	0207	7.5886	$522.67	.	$104.54
62319	Inject spine w/cath l/s (cd)	CH	T	0203	12.7951	$881.28	.	$176.26
62350	Implant spinal canal cath		T	0224	41.9167	$2,887.05	.	$577.41
62351	Implant spinal canal cath		T	0208	51.3375	$3,535.92	.	$707.19
62355	Remove spinal canal catheter		T	0203	12.7951	$881.28	.	$176.26
62360	Insert spine infusion device		T	0224	41.9167	$2,887.05	.	$577.41
62361	Implant spine infusion pump		T	0227	193.1752	$13,305.14	.	$2,661.03
62362	Implant spine infusion pump		T	0227	193.1752	$13,305.14	.	$2,661.03
62365	Remove spine infusion device		T	0221	37.2747	$2,567.33	.	$513.47
62367	Analyze spine infusion pump		S	0691	2.4221	$166.82	.	$33.37
62368	Analyze spine infusion pump		S	0691	2.4221	$166.82	.	$33.37
63001	Removal of spinal lamina		T	0208	51.3375	$3,535.92	.	$707.19
63003	Removal of spinal lamina		T	0208	51.3375	$3,535.92	.	$707.19
63005	Removal of spinal lamina		T	0208	51.3375	$3,535.92	.	$707.19
63011	Removal of spinal lamina		T	0208	51.3375	$3,535.92	.	$707.19
63012	Removal of spinal lamina		T	0208	51.3375	$3,535.92	.	$707.19
63015	Removal of spinal lamina		T	0208	51.3375	$3,535.92	.	$707.19
63016	Removal of spinal lamina		T	0208	51.3375	$3,535.92	.	$707.19
63017	Removal of spinal lamina		T	0208	51.3375	$3,535.92	.	$707.19
63020	Neck spine disk surgery		T	0208	51.3375	$3,535.92	.	$707.19
63030	Low back disk surgery		T	0208	51.3375	$3,535.92	.	$707.19
63035	Spinal disk surgery add-on		T	0208	51.3375	$3,535.92	.	$707.19
63040	Laminotomy single cervical		T	0208	51.3375	$3,535.92	.	$707.19
63042	Laminotomy single lumbar		T	0208	51.3375	$3,535.92	.	$707.19
63043	Laminotomy addl cervical		C					
63044	Laminotomy addl lumbar		C					
63045	Removal of spinal lamina		T	0208	51.3375	$3,535.92	.	$707.19
63046	Removal of spinal lamina		T	0208	51.3375	$3,535.92	.	$707.19
63047	Removal of spinal lamina		T	0208	51.3375	$3,535.92	.	$707.19
63048	Remove spinal lamina add-on		T	0208	51.3375	$3,535.92	.	$707.19
63050	Cervical laminoplasty		C					
63051	C-laminoplasty w/graft/plate		C					
63055	Decompress spinal cord		T	0208	51.3375	$3,535.92	.	$707.19
63056	Decompress spinal cord		T	0208	51.3375	$3,535.92	.	$707.19
63057	Decompress spine cord add-on		T	0208	51.3375	$3,535.92	.	$707.19
63064	Decompress spinal cord		T	0208	51.3375	$3,535.92	.	$707.19
63066	Decompress spine cord add-on		T	0208	51.3375	$3,535.92	.	$707.19
63075	Neck spine disk surgery		T	0208	51.3375	$3,535.92	.	$707.19
63076	Neck spine disk surgery		T	0208	51.3375	$3,535.92	.	$707.19

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63077	Spine disk surgery thorax		C					
63078	Spine disk surgery thorax		C					
63081	Removal of vertebral body		C					
63082	Remove vertebral body add-on		C					
63085	Removal of vertebral body		C					
63086	Remove vertebral body add-on		C					
63087	Removal of vertebral body		C					
63088	Remove vertebral body add-on		C					
63090	Removal of vertebral body		C					
63091	Remove vertebral body add-on		C					
63101	Removal of vertebral body		C					
63102	Removal of vertebral body		C					
63103	Remove vertebral body add-on		C					
63170	Incise spinal cord tract(s)		C					
63172	Drainage of spinal cyst		C					
63173	Drainage of spinal cyst		C					
63180	Revise spinal cord ligaments		C					
63182	Revise spinal cord ligaments		C					
63185	Incise spinal column/nerves		C					
63190	Incise spinal column/nerves		C					
63191	Incise spinal column/nerves		C					
63194	Incise spinal column & cord		C					
63195	Incise spinal column & cord		C					
63196	Incise spinal column & cord		C					
63197	Incise spinal column & cord		C					
63198	Incise spinal column & cord		C					
63199	Incise spinal column & cord		C					
63200	Release of spinal cord		C					
63250	Revise spinal cord vessels		C					
63251	Revise spinal cord vessels		C					
63252	Revise spinal cord vessels		C					
63265	Excise intraspinal lesion		C					
63266	Excise intraspinal lesion		C					
63267	Excise intraspinal lesion		C					
63268	Excise intraspinal lesion		C					
63270	Excise intraspinal lesion		C					
63271	Excise intraspinal lesion		C					
63272	Excise intraspinal lesion		C					
63273	Excise intraspinal lesion		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63275	Biopsy/excise spinal tumor		C					
63276	Biopsy/excise spinal tumor		C					
63277	Biopsy/excise spinal tumor		C					
63278	Biopsy/excise spinal tumor		C					
63280	Biopsy/excise spinal tumor		C					
63281	Biopsy/excise spinal tumor		C					
63282	Biopsy/excise spinal tumor		C					
63283	Biopsy/excise spinal tumor		C					
63285	Biopsy/excise spinal tumor		C					
63286	Biopsy/excise spinal tumor		C					
63287	Biopsy/excise spinal tumor		C					
63290	Biopsy/excise spinal tumor		C					
63295	Repair of laminectomy defect		C					
63300	Removal of vertebral body		C					
63301	Removal of vertebral body		C					
63302	Removal of vertebral body		C					
63303	Removal of vertebral body		C					
63304	Removal of vertebral body		C					
63305	Removal of vertebral body		C					
63306	Removal of vertebral body		C					
63307	Removal of vertebral body		C					
63308	Remove vertebral body add-on		C					
63600	Remove spinal cord lesion		T	0220	19.1325	$1,317.77	.	$263.56
63610	Stimulation of spinal cord		T	0220	19.1325	$1,317.77	.	$263.56
63615	Remove lesion of spinal cord		T	0220	19.1325	$1,317.77	.	$263.56
63620	Srs spinal lesion		B					
63621	Srs spinal lesion addl		B					
63650	Implant neuroelectrodes		S	0040	66.1046	$4,553.02	.	$910.61
63655	Implant neuroelectrodes		S	0061	90.0429	$6,201.79	.	$1,240.36
63661	Remove spine eltrd perq aray		T	0687	21.7224	$1,496.15	$397.37	$299.23
63662	Remove spine eltrd plate		T	0687	21.7224	$1,496.15	$397.37	$299.23
63663	Revise spine eltrd perq aray		T	0687	21.7224	$1,496.15	$397.37	$299.23
63664	Revise spine eltrd plate		T	0687	21.7224	$1,496.15	$397.37	$299.23
63685	Insrt/redo spine n generator		S	0039	214.0597	$14,743.58	.	$2,948.72
63688	Revise/remove neuroreceiver		T	0688	29.0860	$2,003.33	$768.94	$400.67
63700	Repair of spinal herniation		C					
63702	Repair of spinal herniation		C					
63704	Repair of spinal herniation		C					
63706	Repair of spinal herniation		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63707	Repair spinal fluid leakage		C					
63709	Repair spinal fluid leakage		C					
63710	Graft repair of spine defect		C					
63740	Install spinal shunt		C					
63741	Install spinal shunt		T	0224	41.9167	$2,887.05	.	$577.41
63744	Revision of spinal shunt		T	0224	41.9167	$2,887.05	.	$577.41
63746	Removal of spinal shunt		T	0203	12.7951	$881.28	.	$176.26
64400	N block inj trigeminal		T	0204	2.6683	$183.78	$40.13	$36.76
64402	N block inj facial		T	0204	2.6683	$183.78	$40.13	$36.76
64405	N block inj occipital		T	0206	3.8823	$267.40	.	$53.48
64408	N block inj vagus		T	0207	7.5886	$522.67	.	$104.54
64410	N block inj phrenic		T	0207	7.5886	$522.67	.	$104.54
64412	N block inj spinal accessor		T	0207	7.5886	$522.67	.	$104.54
64413	N block inj cervical plexus		T	0206	3.8823	$267.40	.	$53.48
64415	N block inj brachial plexus		T	0206	3.8823	$267.40	.	$53.48
64416	N block cont infuse b plex		T	0207	7.5886	$522.67	.	$104.54
64417	N block inj axillary		T	0206	3.8823	$267.40	.	$53.48
64418	N block inj suprascapular		T	0206	3.8823	$267.40	.	$53.48
64420	N block inj intercost sng		T	0206	3.8823	$267.40	.	$53.48
64421	N block inj intercost mlt		T	0207	7.5886	$522.67	.	$104.54
64425	N block inj ilio-ing/hypogi		T	0206	3.8823	$267.40	.	$53.48
64430	N block inj pudendal		T	0207	7.5886	$522.67	.	$104.54
64435	N block inj paracervical		T	0206	3.8823	$267.40	.	$53.48
64445	N block inj sciatic sng		T	0207	7.5886	$522.67	.	$104.54
64446	N blk inj sciatic cont inf		T	0207	7.5886	$522.67	.	$104.54
64447	N block inj fem single		T	0206	3.8823	$267.40	.	$53.48
64448	N block inj fem cont inf		T	0207	7.5886	$522.67	.	$104.54
64449	N block inj lumbar plexus		T	0207	7.5886	$522.67	.	$104.54
64450	N block other peripheral		T	0206	3.8823	$267.40	.	$53.48
64455	N block inj plantar digit		T	0204	2.6683	$183.78	$40.13	$36.76
64479	Inj foramen epidural c/t		T	0207	7.5886	$522.67	.	$104.54
64480	Inj foramen epidural add-on		T	0206	3.8823	$267.40	.	$53.48
64483	Inj foramen epidural l/s		T	0207	7.5886	$522.67	.	$104.54
64484	Inj foramen epidural add-on		T	0206	3.8823	$267.40	.	$53.48
64490	Inj paravert f jnt c/t 1 lev		T	0207	7.5886	$522.67	.	$104.54
64491	Inj paravert f jnt c/t 2 lev		T	0204	2.6683	$183.78	$40.13	$36.76
64492	Inj paravert f jnt c/t 3 lev		T	0204	2.6683	$183.78	$40.13	$36.76
64493	Inj paravert f jnt l/s 1 lev		T	0207	7.5886	$522.67	.	$104.54
64494	Inj paravert f jnt l/s 2 lev		T	0204	2.6683	$183.78	$40.13	$36.76

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

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64495	Inj paravert f jnt l/s 3 lev		T	0204	2.6683	$183.78	$40.13	$36.76
64505	N block spenopalatine gangl		T	0204	2.6683	$183.78	$40.13	$36.76
64508	N block carotid sinus s/p		T	0204	2.6683	$183.78	$40.13	$36.76
64510	N block stellate ganglion		T	0207	7.5886	$522.67	.	$104.54
64517	N block inj hypogas plxs		T	0207	7.5886	$522.67	.	$104.54
64520	N block lumbar/thoracic		T	0207	7.5886	$522.67	.	$104.54
64530	N block inj celiac pelus		T	0207	7.5886	$522.67	.	$104.54
64550	Apply neurostimulator		A					
64553	Implant neuroelectrodes		S	0040	66.1046	$4,553.02	.	$910.61
64555	Implant neuroelectrodes		S	0040	66.1046	$4,553.02	.	$910.61
64560	Implant neuroelectrodes		S	0040	66.1046	$4,553.02	.	$910.61
64561	Implant neuroelectrodes		S	0040	66.1046	$4,553.02	.	$910.61
64565	Implant neuroelectrodes		S	0040	66.1046	$4,553.02	.	$910.61
64566	Neuroeltrd stim post tibial	NI	T	0204	2.6683	$183.78	$40.13	$36.76
64568	Inc for vagus n elect impl	NI	S	0318	331.0938	$22,804.42	$9,121.76	$4,560.89
64569	Revise/repl vagus n eltrd	NI	T	0687	21.7224	$1,496.15	$397.37	$299.23
64570	Remove vagus n eltrd	NI	T	0221	37.2747	$2,567.33	.	$513.47
64573	Implant neuroelectrodes	CH	D					
64575	Implant neuroelectrodes		S	0061	90.0429	$6,201.79	.	$1,240.36
64577	Implant neuroelectrodes		S	0061	90.0429	$6,201.79	.	$1,240.36
64580	Implant neuroelectrodes		S	0061	90.0429	$6,201.79	.	$1,240.36
64581	Implant neuroelectrodes		S	0061	90.0429	$6,201.79	.	$1,240.36
64585	Revise/remove neuroelectrode		T	0687	21.7224	$1,496.15	$397.37	$299.23
64590	Insrt/redo pn/gastr stimul		S	0039	214.0597	$14,743.58	.	$2,948.72
64595	Revise/rmv pn/gastr stimul		T	0688	29.0860	$2,003.33	$768.94	$400.67
64600	Injection treatment of nerve		T	0203	12.7951	$881.28	.	$176.26
64605	Injection treatment of nerve		T	0220	19.1325	$1,317.77	.	$263.56
64610	Injection treatment of nerve		T	0220	19.1325	$1,317.77	.	$263.56
64611	Chemodenerv saliv glands	NI	T	0204	2.6683	$183.78	$40.13	$36.76
64612	Destroy nerve face muscle		T	0204	2.6683	$183.78	$40.13	$36.76
64613	Destroy nerve neck muscle		T	0206	3.8823	$267.40	.	$53.48
64614	Destroy nerve extrem musc		T	0206	3.8823	$267.40	.	$53.48
64620	Injection treatment of nerve		T	0207	7.5886	$522.67	.	$104.54
64622	Destr paravertebrl nerve l/s		T	0203	12.7951	$881.28	.	$176.26
64623	Destr paravertebral n add-on		T	0207	7.5886	$522.67	.	$104.54
64626	Destr paravertebrl nerve c/t		T	0207	7.5886	$522.67	.	$104.54
64627	Destr paravertebral n add-on		T	0204	2.6683	$183.78	$40.13	$36.76
64630	Injection treatment of nerve		T	0207	7.5886	$522.67	.	$104.54
64632	N block inj common digit		T	0204	2.6683	$183.78	$40.13	$36.76

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

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64640	Injection treatment of nerve		T	0207	7.5886	$522.67	.	$104.54
64650	Chemodenerv eccrine glands		T	0204	2.6683	$183.78	$40.13	$36.76
64653	Chemodenerv eccrine glands		T	0204	2.6683	$183.78	$40.13	$36.76
64680	Injection treatment of nerve		T	0207	7.5886	$522.67	.	$104.54
64681	Injection treatment of nerve		T	0203	12.7951	$881.28	.	$176.26
64702	Revise finger/toe nerve		T	0220	19.1325	$1,317.77	.	$263.56
64704	Revise hand/foot nerve		T	0220	19.1325	$1,317.77	.	$263.56
64708	Revise arm/leg nerve		T	0220	19.1325	$1,317.77	.	$263.56
64712	Revision of sciatic nerve		T	0220	19.1325	$1,317.77	.	$263.56
64713	Revision of arm nerve(s)		T	0220	19.1325	$1,317.77	.	$263.56
64714	Revise low back nerve(s)		T	0220	19.1325	$1,317.77	.	$263.56
64716	Revision of cranial nerve		T	0220	19.1325	$1,317.77	.	$263.56
64718	Revise ulnar nerve at elbow		T	0220	19.1325	$1,317.77	.	$263.56
64719	Revise ulnar nerve at wrist		T	0220	19.1325	$1,317.77	.	$263.56
64721	Carpal tunnel surgery		T	0220	19.1325	$1,317.77	.	$263.56
64722	Relieve pressure on nerve(s)		T	0220	19.1325	$1,317.77	.	$263.56
64726	Release foot/toe nerve		T	0220	19.1325	$1,317.77	.	$263.56
64727	Internal nerve revision		T	0220	19.1325	$1,317.77	.	$263.56
64732	Incision of brow nerve		T	0220	19.1325	$1,317.77	.	$263.56
64734	Incision of cheek nerve		T	0220	19.1325	$1,317.77	.	$263.56
64736	Incision of chin nerve		T	0220	19.1325	$1,317.77	.	$263.56
64738	Incision of jaw nerve		T	0220	19.1325	$1,317.77	.	$263.56
64740	Incision of tongue nerve		T	0220	19.1325	$1,317.77	.	$263.56
64742	Incision of facial nerve		T	0220	19.1325	$1,317.77	.	$263.56
64744	Incise nerve back of head		T	0220	19.1325	$1,317.77	.	$263.56
64746	Incise diaphragm nerve		T	0220	19.1325	$1,317.77	.	$263.56
64752	Incision of vagus nerve		C					
64755	Incision of stomach nerves		C					
64760	Incision of vagus nerve		C					
64761	Incision of pelvis nerve		T	0220	19.1325	$1,317.77	.	$263.56
64763	Incise hip/thigh nerve		T	0220	19.1325	$1,317.77	.	$263.56
64766	Incise hip/thigh nerve		T	0221	37.2747	$2,567.33	.	$513.47
64771	Sever cranial nerve		T	0220	19.1325	$1,317.77	.	$263.56
64772	Incision of spinal nerve		T	0220	19.1325	$1,317.77	.	$263.56
64774	Remove skin nerve lesion		T	0220	19.1325	$1,317.77	.	$263.56
64776	Remove digit nerve lesion		T	0220	19.1325	$1,317.77	.	$263.56
64778	Digit nerve surgery add-on		T	0220	19.1325	$1,317.77	.	$263.56
64782	Remove limb nerve lesion		T	0220	19.1325	$1,317.77	.	$263.56
64783	Limb nerve surgery add-on		T	0220	19.1325	$1,317.77	.	$263.56

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64784	Remove nerve lesion		T	0220	19.1325	$1,317.77	.	$263.56
64786	Remove sciatic nerve lesion		T	0221	37.2747	$2,567.33	.	$513.47
64787	Implant nerve end		T	0220	19.1325	$1,317.77	.	$263.56
64788	Remove skin nerve lesion		T	0220	19.1325	$1,317.77	.	$263.56
64790	Removal of nerve lesion		T	0220	19.1325	$1,317.77	.	$263.56
64792	Removal of nerve lesion		T	0221	37.2747	$2,567.33	.	$513.47
64795	Biopsy of nerve		T	0220	19.1325	$1,317.77	.	$263.56
64802	Remove sympathetic nerves		T	0220	19.1325	$1,317.77	.	$263.56
64804	Remove sympathetic nerves		T	0220	19.1325	$1,317.77	.	$263.56
64809	Remove sympathetic nerves		C					
64818	Remove sympathetic nerves		C					
64820	Remove sympathetic nerves		T	0220	19.1325	$1,317.77	.	$263.56
64821	Remove sympathetic nerves		T	0054	29.7686	$2,050.34	.	$410.07
64822	Remove sympathetic nerves		T	0054	29.7686	$2,050.34	.	$410.07
64823	Remove sympathetic nerves		T	0054	29.7686	$2,050.34	.	$410.07
64831	Repair of digit nerve		T	0221	37.2747	$2,567.33	.	$513.47
64832	Repair nerve add-on		T	0221	37.2747	$2,567.33	.	$513.47
64834	Repair of hand or foot nerve		T	0221	37.2747	$2,567.33	.	$513.47
64835	Repair of hand or foot nerve		T	0221	37.2747	$2,567.33	.	$513.47
64836	Repair of hand or foot nerve		T	0221	37.2747	$2,567.33	.	$513.47
64837	Repair nerve add-on		T	0221	37.2747	$2,567.33	.	$513.47
64840	Repair of leg nerve		T	0221	37.2747	$2,567.33	.	$513.47
64856	Repair/transpose nerve		T	0221	37.2747	$2,567.33	.	$513.47
64857	Repair arm/leg nerve		T	0221	37.2747	$2,567.33	.	$513.47
64858	Repair sciatic nerve		T	0221	37.2747	$2,567.33	.	$513.47
64859	Nerve surgery		T	0221	37.2747	$2,567.33	.	$513.47
64861	Repair of arm nerves		T	0221	37.2747	$2,567.33	.	$513.47
64862	Repair of low back nerves		T	0221	37.2747	$2,567.33	.	$513.47
64864	Repair of facial nerve		T	0221	37.2747	$2,567.33	.	$513.47
64865	Repair of facial nerve		T	0221	37.2747	$2,567.33	.	$513.47
64866	Fusion of facial/other nerve		C					
64868	Fusion of facial/other nerve		C					
64870	Fusion of facial/other nerve		T	0221	37.2747	$2,567.33	.	$513.47
64872	Subsequent repair of nerve		T	0221	37.2747	$2,567.33	.	$513.47
64874	Repair & revise nerve add-on		T	0221	37.2747	$2,567.33	.	$513.47
64876	Repair nerve/shorten bone		T	0221	37.2747	$2,567.33	.	$513.47
64885	Nerve graft head or neck		T	0221	37.2747	$2,567.33	.	$513.47
64886	Nerve graft head or neck		T	0221	37.2747	$2,567.33	.	$513.47
64890	Nerve graft hand or foot		T	0221	37.2747	$2,567.33	.	$513.47

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64891	Nerve graft hand or foot		T	0221	37.2747	$2,567.33	.	$513.47
64892	Nerve graft arm or leg		T	0221	37.2747	$2,567.33	.	$513.47
64893	Nerve graft arm or leg		T	0221	37.2747	$2,567.33	.	$513.47
64895	Nerve graft hand or foot		T	0221	37.2747	$2,567.33	.	$513.47
64896	Nerve graft hand or foot		T	0221	37.2747	$2,567.33	.	$513.47
64897	Nerve graft arm or leg		T	0221	37.2747	$2,567.33	.	$513.47
64898	Nerve graft arm or leg		T	0221	37.2747	$2,567.33	.	$513.47
64901	Nerve graft add-on		T	0221	37.2747	$2,567.33	.	$513.47
64902	Nerve graft add-on		T	0221	37.2747	$2,567.33	.	$513.47
64905	Nerve pedicle transfer		T	0221	37.2747	$2,567.33	.	$513.47
64907	Nerve pedicle transfer		T	0221	37.2747	$2,567.33	.	$513.47
64910	Nerve repair w/allograft		T	0221	37.2747	$2,567.33	.	$513.47
64911	Neurorraphy w/vein autograft		T	0221	37.2747	$2,567.33	.	$513.47
64999	Nervous system surgery		T	0204	2.6683	$183.78	$40.13	$36.76
65091	Revise eye		T	0242	38.8370	$2,674.94	$597.36	$534.99
65093	Revise eye with implant		T	0242	38.8370	$2,674.94	$597.36	$534.99
65101	Removal of eye		T	0242	38.8370	$2,674.94	$597.36	$534.99
65103	Remove eye/insert implant		T	0242	38.8370	$2,674.94	$597.36	$534.99
65105	Remove eye/attach implant		T	0242	38.8370	$2,674.94	$597.36	$534.99
65110	Removal of eye		T	0242	38.8370	$2,674.94	$597.36	$534.99
65112	Remove eye/revise socket		T	0242	38.8370	$2,674.94	$597.36	$534.99
65114	Remove eye/revise socket		T	0242	38.8370	$2,674.94	$597.36	$534.99
65125	Revise ocular implant		T	0241	26.5964	$1,831.85	$383.45	$366.37
65130	Insert ocular implant		T	0241	26.5964	$1,831.85	$383.45	$366.37
65135	Insert ocular implant		T	0241	26.5964	$1,831.85	$383.45	$366.37
65140	Attach ocular implant		T	0242	38.8370	$2,674.94	$597.36	$534.99
65150	Revise ocular implant		T	0241	26.5964	$1,831.85	$383.45	$366.37
65155	Reinsert ocular implant		T	0242	38.8370	$2,674.94	$597.36	$534.99
65175	Removal of ocular implant		T	0240	20.0091	$1,378.15	$296.20	$275.63
65205	Remove foreign body from eye		S	0698	0.9697	$66.79	.	$13.36
65210	Remove foreign body from eye		S	0698	0.9697	$66.79	.	$13.36
65220	Remove foreign body from eye		S	0698	0.9697	$66.79	.	$13.36
65222	Remove foreign body from eye		S	0698	0.9697	$66.79	.	$13.36
65235	Remove foreign body from eye		T	0233	17.9021	$1,233.03	$263.12	$246.61
65260	Remove foreign body from eye		T	0235	5.8452	$402.59	.	$80.52
65265	Remove foreign body from eye		T	0237	23.4306	$1,613.81	.	$322.77
65270	Repair of eye wound		T	0240	20.0091	$1,378.15	$296.20	$275.63
65272	Repair of eye wound		T	0234	24.4149	$1,681.60	$511.31	$336.32
65273	Repair of eye wound		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65275	Repair of eye wound		T	0234	24.4149	$1,681.60	$511.31	$336.32
65280	Repair of eye wound		T	0237	23.4306	$1,613.81	.	$322.77
65285	Repair of eye wound		T	0672	40.9566	$2,820.93	.	$564.19
65286	Repair of eye wound	CH	T	0255	7.5341	$518.92	$124.97	$103.79
65290	Repair of eye socket wound		T	0243	25.5895	$1,762.50	$416.98	$352.50
65400	Removal of eye lesion		T	0233	17.9021	$1,233.03	$263.12	$246.61
65410	Biopsy of cornea		T	0233	17.9021	$1,233.03	$263.12	$246.61
65420	Removal of eye lesion		T	0233	17.9021	$1,233.03	$263.12	$246.61
65426	Removal of eye lesion		T	0234	24.4149	$1,681.60	$511.31	$336.32
65430	Corneal smear		S	0698	0.9697	$66.79	.	$13.36
65435	Curette/treat cornea		T	0239	8.1226	$559.45	.	$111.89
65436	Curette/treat cornea		T	0233	17.9021	$1,233.03	$263.12	$246.61
65450	Treatment of corneal lesion		S	0231	2.3078	$158.95	.	$31.79
65600	Revision of cornea		T	0240	20.0091	$1,378.15	$296.20	$275.63
65710	Corneal transplant		T	0244	38.9282	$2,681.22	$803.26	$536.25
65730	Corneal transplant		T	0244	38.9282	$2,681.22	$803.26	$536.25
65750	Corneal transplant		T	0244	38.9282	$2,681.22	$803.26	$536.25
65755	Corneal transplant		T	0244	38.9282	$2,681.22	$803.26	$536.25
65756	Corneal trnspl endothelial		T	0244	38.9282	$2,681.22	$803.26	$536.25
65757	Prep corneal endo allograft		N					
65760	Revision of cornea		E					
65765	Revision of cornea		E					
65767	Corneal tissue transplant		E					
65770	Revise cornea with implant		T	0293	109.7404	$7,558.48	.	$1,511.70
65771	Radial keratotomy		E					
65772	Correction of astigmatism		T	0233	17.9021	$1,233.03	$263.12	$246.61
65775	Correction of astigmatism		T	0233	17.9021	$1,233.03	$263.12	$246.61
65778	Cover eye w/membrane	NI	T	0239	8.1226	$559.45	.	$111.89
65779	Cover eye w/membrane stent	NI	T	0255	7.5341	$518.92	$124.97	$103.79
65780	Ocular reconst transplant		T	0244	38.9282	$2,681.22	$803.26	$536.25
65781	Ocular reconst transplant		T	0244	38.9282	$2,681.22	$803.26	$536.25
65782	Ocular reconst transplant		T	0244	38.9282	$2,681.22	$803.26	$536.25
65800	Drainage of eye	CH	T	0255	7.5341	$518.92	$124.97	$103.79
65805	Drainage of eye		T	0233	17.9021	$1,233.03	$263.12	$246.61
65810	Drainage of eye		T	0234	24.4149	$1,681.60	$511.31	$336.32
65815	Drainage of eye		T	0234	24.4149	$1,681.60	$511.31	$336.32
65820	Relieve inner eye pressure	CH	T	0234	24.4149	$1,681.60	$511.31	$336.32
65850	Incision of eye		T	0234	24.4149	$1,681.60	$511.31	$336.32
65855	Laser surgery of eye		T	0247	5.6106	$386.44	$104.31	$77.29

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65860	Incise inner eye adhesions		T	0247	5.6106	$386.44	$104.31	$77.29
65865	Incise inner eye adhesions		T	0233	17.9021	$1,233.03	$263.12	$246.61
65870	Incise inner eye adhesions		T	0234	24.4149	$1,681.60	$511.31	$336.32
65875	Incise inner eye adhesions		T	0234	24.4149	$1,681.60	$511.31	$336.32
65880	Incise inner eye adhesions		T	0233	17.9021	$1,233.03	$263.12	$246.61
65900	Remove eye lesion	CH	T	0232	2.5480	$175.50	$42.27	$35.10
65920	Remove implant of eye		T	0234	24.4149	$1,681.60	$511.31	$336.32
65930	Remove blood clot from eye		T	0234	24.4149	$1,681.60	$511.31	$336.32
66020	Injection treatment of eye		T	0233	17.9021	$1,233.03	$263.12	$246.61
66030	Injection treatment of eye	CH	T	0233	17.9021	$1,233.03	$263.12	$246.61
66130	Remove eye lesion		T	0234	24.4149	$1,681.60	$511.31	$336.32
66150	Glaucoma surgery		T	0234	24.4149	$1,681.60	$511.31	$336.32
66155	Glaucoma surgery		T	0234	24.4149	$1,681.60	$511.31	$336.32
66160	Glaucoma surgery		T	0234	24.4149	$1,681.60	$511.31	$336.32
66165	Glaucoma surgery		T	0234	24.4149	$1,681.60	$511.31	$336.32
66170	Glaucoma surgery		T	0234	24.4149	$1,681.60	$511.31	$336.32
66172	Incision of eye		T	0234	24.4149	$1,681.60	$511.31	$336.32
66174	Translum dil eye canal	NI	T	0673	43.2387	$2,978.11	$649.56	$595.63
66175	Trnslum dil eye canal w/stnt	NI	T	0673	43.2387	$2,978.11	$649.56	$595.63
66180	Implant eye shunt		T	0673	43.2387	$2,978.11	$649.56	$595.63
66185	Revise eye shunt		T	0234	24.4149	$1,681.60	$511.31	$336.32
66220	Repair eye lesion		T	0672	40.9566	$2,820.93	.	$564.19
66225	Repair/graft eye lesion		T	0673	43.2387	$2,978.11	$649.56	$595.63
66250	Follow-up surgery of eye		T	0233	17.9021	$1,233.03	$263.12	$246.61
66500	Incision of iris		T	0232	2.5480	$175.50	$42.27	$35.10
66505	Incision of iris	CH	T	0255	7.5341	$518.92	$124.97	$103.79
66600	Remove iris and lesion		T	0234	24.4149	$1,681.60	$511.31	$336.32
66605	Removal of iris		T	0234	24.4149	$1,681.60	$511.31	$336.32
66625	Removal of iris	CH	T	0255	7.5341	$518.92	$124.97	$103.79
66630	Removal of iris		T	0234	24.4149	$1,681.60	$511.31	$336.32
66635	Removal of iris		T	0234	24.4149	$1,681.60	$511.31	$336.32
66680	Repair iris & ciliary body		T	0234	24.4149	$1,681.60	$511.31	$336.32
66682	Repair iris & ciliary body		T	0234	24.4149	$1,681.60	$511.31	$336.32
66700	Destruction ciliary body		T	0233	17.9021	$1,233.03	$263.12	$246.61
66710	Ciliary transscleral therapy		T	0233	17.9021	$1,233.03	$263.12	$246.61
66711	Ciliary endoscopic ablation		T	0233	17.9021	$1,233.03	$263.12	$246.61
66720	Destruction ciliary body		T	0233	17.9021	$1,233.03	$263.12	$246.61
66740	Destruction ciliary body		T	0234	24.4149	$1,681.60	$511.31	$336.32
66761	Revision of iris		T	0247	5.6106	$386.44	$104.31	$77.29

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
66762	Revision of iris		T	0247	5.6106	$386.44	$104.31	$77.29
66770	Removal of inner eye lesion		T	0247	5.6106	$386.44	$104.31	$77.29
66820	Incision secondary cataract	CH	T	0255	7.5341	$518.92	$124.97	$103.79
66821	After cataract laser surgery		T	0247	5.6106	$386.44	$104.31	$77.29
66825	Reposition intraocular lens		T	0234	24.4149	$1,681.60	$511.31	$336.32
66830	Removal of lens lesion	CH	T	0255	7.5341	$518.92	$124.97	$103.79
66840	Removal of lens material		T	0245	14.7683	$1,017.18	$204.88	$203.44
66850	Removal of lens material		T	0249	30.8241	$2,123.04	$516.99	$424.61
66852	Removal of lens material		T	0249	30.8241	$2,123.04	$516.99	$424.61
66920	Extraction of lens		T	0249	30.8241	$2,123.04	$516.99	$424.61
66930	Extraction of lens		T	0249	30.8241	$2,123.04	$516.99	$424.61
66940	Extraction of lens		T	0245	14.7683	$1,017.18	$204.88	$203.44
66982	Cataract surgery complex		T	0246	24.5531	$1,691.12	$495.96	$338.23
66983	Cataract surg w/iol 1 stage		T	0246	24.5531	$1,691.12	$495.96	$338.23
66984	Cataract surg w/iol 1 stage		T	0246	24.5531	$1,691.12	$495.96	$338.23
66985	Insert lens prosthesis		T	0246	24.5531	$1,691.12	$495.96	$338.23
66986	Exchange lens prosthesis		T	0246	24.5531	$1,691.12	$495.96	$338.23
66990	Ophthalmic endoscope add-on		N					
66999	Eye surgery procedure		T	0232	2.5480	$175.50	$42.27	$35.10
67005	Partial removal of eye fluid		T	0237	23.4306	$1,613.81	.	$322.77
67010	Partial removal of eye fluid		T	0672	40.9566	$2,820.93	.	$564.19
67015	Release of eye fluid		T	0672	40.9566	$2,820.93	.	$564.19
67025	Replace eye fluid	CH	T	0672	40.9566	$2,820.93	.	$564.19
67027	Implant eye drug system		T	0672	40.9566	$2,820.93	.	$564.19
67028	Injection eye drug		T	0238	3.2520	$223.98	.	$44.80
67030	Incise inner eye strands		T	0237	23.4306	$1,613.81	.	$322.77
67031	Laser surgery eye strands		T	0247	5.6106	$386.44	$104.31	$77.29
67036	Removal of inner eye fluid		T	0672	40.9566	$2,820.93	.	$564.19
67039	Laser treatment of retina		T	0672	40.9566	$2,820.93	.	$564.19
67040	Laser treatment of retina		T	0672	40.9566	$2,820.93	.	$564.19
67041	Vit for macular pucker		T	0672	40.9566	$2,820.93	.	$564.19
67042	Vit for macular hole		T	0672	40.9566	$2,820.93	.	$564.19
67043	Vit for membrane dissect		T	0672	40.9566	$2,820.93	.	$564.19
67101	Repair detached retina		T	0237	23.4306	$1,613.81	.	$322.77
67105	Repair detached retina		T	0247	5.6106	$386.44	$104.31	$77.29
67107	Repair detached retina		T	0672	40.9566	$2,820.93	.	$564.19
67108	Repair detached retina		T	0672	40.9566	$2,820.93	.	$564.19
67110	Repair detached retina		T	0237	23.4306	$1,613.81	.	$322.77
67112	Rerepair detached retina		T	0672	40.9566	$2,820.93	.	$564.19

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67113	Repair retinal detach cplx		T	0672	40.9566	$2,820.93	.	$564.19
67115	Release encircling material		T	0237	23.4306	$1,613.81	.	$322.77
67120	Remove eye implant material		T	0237	23.4306	$1,613.81	.	$322.77
67121	Remove eye implant material	CH	T	0672	40.9566	$2,820.93	.	$564.19
67141	Treatment of retina		T	0235	5.8452	$402.59	.	$80.52
67145	Treatment of retina		T	0247	5.6106	$386.44	$104.31	$77.29
67208	Treatment of retinal lesion		T	0235	5.8452	$402.59	.	$80.52
67210	Treatment of retinal lesion		T	0247	5.6106	$386.44	$104.31	$77.29
67218	Treatment of retinal lesion		T	0237	23.4306	$1,613.81	.	$322.77
67220	Treatment of choroid lesion		T	0235	5.8452	$402.59	.	$80.52
67221	Ocular photodynamic ther		T	0235	5.8452	$402.59	.	$80.52
67225	Eye photodynamic ther add-on		T	0235	5.8452	$402.59	.	$80.52
67227	Treatment of retinal lesion		T	0237	23.4306	$1,613.81	.	$322.77
67228	Treatment of retinal lesion		T	0247	5.6106	$386.44	$104.31	$77.29
67229	Tr retinal les preterm inf		T	0247	5.6106	$386.44	$104.31	$77.29
67250	Reinforce eye wall		T	0240	20.0091	$1,378.15	$296.20	$275.63
67255	Reinforce/graft eye wall		T	0237	23.4306	$1,613.81	.	$322.77
67299	Eye surgery procedure		T	0235	5.8452	$402.59	.	$80.52
67311	Revise eye muscle		T	0243	25.5895	$1,762.50	$416.98	$352.50
67312	Revise two eye muscles		T	0243	25.5895	$1,762.50	$416.98	$352.50
67314	Revise eye muscle		T	0243	25.5895	$1,762.50	$416.98	$352.50
67316	Revise two eye muscles		T	0243	25.5895	$1,762.50	$416.98	$352.50
67318	Revise eye muscle(s)		T	0243	25.5895	$1,762.50	$416.98	$352.50
67320	Revise eye muscle(s) add-on		T	0243	25.5895	$1,762.50	$416.98	$352.50
67331	Eye surgery follow-up add-on		T	0243	25.5895	$1,762.50	$416.98	$352.50
67332	Rerevise eye muscles add-on		T	0243	25.5895	$1,762.50	$416.98	$352.50
67334	Revise eye muscle w/suture		T	0243	25.5895	$1,762.50	$416.98	$352.50
67335	Eye suture during surgery		T	0243	25.5895	$1,762.50	$416.98	$352.50
67340	Revise eye muscle add-on		T	0243	25.5895	$1,762.50	$416.98	$352.50
67343	Release eye tissue		T	0243	25.5895	$1,762.50	$416.98	$352.50
67345	Destroy nerve of eye muscle		T	0238	3.2520	$223.98	.	$44.80
67346	Biopsy eye muscle		T	0699	16.7862	$1,156.17	.	$231.24
67399	Eye muscle surgery procedure		T	0243	25.5895	$1,762.50	$416.98	$352.50
67400	Explore/biopsy eye socket		T	0240	20.0091	$1,378.15	$296.20	$275.63
67405	Explore/drain eye socket		T	0241	26.5964	$1,831.85	$383.45	$366.37
67412	Explore/treat eye socket		T	0240	20.0091	$1,378.15	$296.20	$275.63
67413	Explore/treat eye socket		T	0241	26.5964	$1,831.85	$383.45	$366.37
67414	Explr/decompress eye socket		T	0242	38.8370	$2,674.94	$597.36	$534.99
67415	Aspiration orbital contents		T	0240	20.0091	$1,378.15	$296.20	$275.63

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67420	Explore/treat eye socket		T	0242	38.8370	$2,674.94	$597.36	$534.99
67430	Explore/treat eye socket		T	0242	38.8370	$2,674.94	$597.36	$534.99
67440	Explore/drain eye socket		T	0242	38.8370	$2,674.94	$597.36	$534.99
67445	Explr/decompress eye socket		T	0242	38.8370	$2,674.94	$597.36	$534.99
67450	Explore/biopsy eye socket		T	0242	38.8370	$2,674.94	$597.36	$534.99
67500	Inject/treat eye socket		S	0231	2.3078	$158.95	.	$31.79
67505	Inject/treat eye socket		T	0238	3.2520	$223.98	.	$44.80
67515	Inject/treat eye socket		T	0238	3.2520	$223.98	.	$44.80
67550	Insert eye socket implant		T	0242	38.8370	$2,674.94	$597.36	$534.99
67560	Revise eye socket implant		T	0241	26.5964	$1,831.85	$383.45	$366.37
67570	Decompress optic nerve		T	0242	38.8370	$2,674.94	$597.36	$534.99
67599	Orbit surgery procedure		T	0238	3.2520	$223.98	.	$44.80
67700	Drainage of eyelid abscess		T	0238	3.2520	$223.98	.	$44.80
67710	Incision of eyelid		T	0239	8.1226	$559.45	.	$111.89
67715	Incision of eyelid fold		T	0240	20.0091	$1,378.15	$296.20	$275.63
67800	Remove eyelid lesion		T	0238	3.2520	$223.98	.	$44.80
67801	Remove eyelid lesions		T	0239	8.1226	$559.45	.	$111.89
67805	Remove eyelid lesions		T	0238	3.2520	$223.98	.	$44.80
67808	Remove eyelid lesion(s)		T	0240	20.0091	$1,378.15	$296.20	$275.63
67810	Biopsy of eyelid		T	0238	3.2520	$223.98	.	$44.80
67820	Revise eyelashes		S	0698	0.9697	$66.79	.	$13.36
67825	Revise eyelashes		T	0238	3.2520	$223.98	.	$44.80
67830	Revise eyelashes		T	0239	8.1226	$559.45	.	$111.89
67835	Revise eyelashes		T	0240	20.0091	$1,378.15	$296.20	$275.63
67840	Remove eyelid lesion		T	0239	8.1226	$559.45	.	$111.89
67850	Treat eyelid lesion		T	0239	8.1226	$559.45	.	$111.89
67875	Closure of eyelid by suture		T	0239	8.1226	$559.45	.	$111.89
67880	Revision of eyelid		T	0233	17.9021	$1,233.03	$263.12	$246.61
67882	Revision of eyelid		T	0240	20.0091	$1,378.15	$296.20	$275.63
67900	Repair brow defect		T	0241	26.5964	$1,831.85	$383.45	$366.37
67901	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67902	Repair eyelid defect		T	0241	26.5964	$1,831.85	$383.45	$366.37
67903	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67904	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67906	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67908	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67909	Revise eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67911	Revise eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67912	Correction eyelid w/implant		T	0240	20.0091	$1,378.15	$296.20	$275.63

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67914	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67915	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67916	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67917	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67921	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67922	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67923	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67924	Repair eyelid defect		T	0240	20.0091	$1,378.15	$296.20	$275.63
67930	Repair eyelid wound		T	0240	20.0091	$1,378.15	$296.20	$275.63
67935	Repair eyelid wound		T	0240	20.0091	$1,378.15	$296.20	$275.63
67938	Remove eyelid foreign body		S	0231	2.3078	$158.95	.	$31.79
67950	Revision of eyelid		T	0240	20.0091	$1,378.15	$296.20	$275.63
67961	Revision of eyelid		T	0240	20.0091	$1,378.15	$296.20	$275.63
67966	Revision of eyelid		T	0240	20.0091	$1,378.15	$296.20	$275.63
67971	Reconstruction of eyelid		T	0240	20.0091	$1,378.15	$296.20	$275.63
67973	Reconstruction of eyelid		T	0241	26.5964	$1,831.85	$383.45	$366.37
67974	Reconstruction of eyelid		T	0240	20.0091	$1,378.15	$296.20	$275.63
67975	Reconstruction of eyelid		T	0240	20.0091	$1,378.15	$296.20	$275.63
67999	Revision of eyelid		T	0238	3.2520	$223.98	.	$44.80
68020	Incise/drain eyelid lining		T	0238	3.2520	$223.98	.	$44.80
68040	Treatment of eyelid lesions		S	0698	0.9697	$66.79	.	$13.36
68100	Biopsy of eyelid lining	CH	T	0255	7.5341	$518.92	$124.97	$103.79
68110	Remove eyelid lining lesion		T	0699	16.7862	$1,156.17	.	$231.24
68115	Remove eyelid lining lesion		T	0240	20.0091	$1,378.15	$296.20	$275.63
68130	Remove eyelid lining lesion		T	0233	17.9021	$1,233.03	$263.12	$246.61
68135	Remove eyelid lining lesion		T	0239	8.1226	$559.45	.	$111.89
68200	Treat eyelid by injection		S	0698	0.9697	$66.79	.	$13.36
68320	Revise/graft eyelid lining		T	0241	26.5964	$1,831.85	$383.45	$366.37
68325	Revise/graft eyelid lining		T	0241	26.5964	$1,831.85	$383.45	$366.37
68326	Revise/graft eyelid lining		T	0240	20.0091	$1,378.15	$296.20	$275.63
68328	Revise/graft eyelid lining		T	0241	26.5964	$1,831.85	$383.45	$366.37
68330	Revise eyelid lining		T	0234	24.4149	$1,681.60	$511.31	$336.32
68335	Revise/graft eyelid lining		T	0241	26.5964	$1,831.85	$383.45	$366.37
68340	Separate eyelid adhesions		T	0240	20.0091	$1,378.15	$296.20	$275.63
68360	Revise eyelid lining		T	0234	24.4149	$1,681.60	$511.31	$336.32
68362	Revise eyelid lining		T	0234	24.4149	$1,681.60	$511.31	$336.32
68371	Harvest eye tissue alograft		T	0233	17.9021	$1,233.03	$263.12	$246.61
68399	Eyelid lining surgery		T	0238	3.2520	$223.98	.	$44.80
68400	Incise/drain tear gland		T	0238	3.2520	$223.98	.	$44.80

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
68420	Incise/drain tear sac		T	0240	20.0091	$1,378.15	$296.20	$275.63
68440	Incise tear duct opening		T	0238	3.2520	$223.98	.	$44.80
68500	Removal of tear gland		T	0241	26.5964	$1,831.85	$383.45	$366.37
68505	Partial removal tear gland		T	0241	26.5964	$1,831.85	$383.45	$366.37
68510	Biopsy of tear gland		T	0240	20.0091	$1,378.15	$296.20	$275.63
68520	Removal of tear sac		T	0241	26.5964	$1,831.85	$383.45	$366.37
68525	Biopsy of tear sac		T	0240	20.0091	$1,378.15	$296.20	$275.63
68530	Clearance of tear duct		T	0238	3.2520	$223.98	.	$44.80
68540	Remove tear gland lesion		T	0240	20.0091	$1,378.15	$296.20	$275.63
68550	Remove tear gland lesion		T	0241	26.5964	$1,831.85	$383.45	$366.37
68700	Repair tear ducts		T	0240	20.0091	$1,378.15	$296.20	$275.63
68705	Revise tear duct opening		T	0238	3.2520	$223.98	.	$44.80
68720	Create tear sac drain		T	0241	26.5964	$1,831.85	$383.45	$366.37
68745	Create tear duct drain		T	0241	26.5964	$1,831.85	$383.45	$366.37
68750	Create tear duct drain		T	0241	26.5964	$1,831.85	$383.45	$366.37
68760	Close tear duct opening		T	0238	3.2520	$223.98	.	$44.80
68761	Close tear duct opening		T	0238	3.2520	$223.98	.	$44.80
68770	Close tear system fistula		T	0241	26.5964	$1,831.85	$383.45	$366.37
68801	Dilate tear duct opening		S	0698	0.9697	$66.79	.	$13.36
68810	Probe nasolacrimal duct		T	0238	3.2520	$223.98	.	$44.80
68811	Probe nasolacrimal duct		T	0240	20.0091	$1,378.15	$296.20	$275.63
68815	Probe nasolacrimal duct		T	0240	20.0091	$1,378.15	$296.20	$275.63
68816	Probe nl duct w/balloon		T	0240	20.0091	$1,378.15	$296.20	$275.63
68840	Explore/irrigate tear ducts		S	0231	2.3078	$158.95	.	$31.79
68850	Injection for tear sac x-ray		N					
68899	Tear duct system surgery		T	0238	3.2520	$223.98	.	$44.80
69000	Drain external ear lesion		T	0006	1.4906	$102.67	.	$20.54
69005	Drain external ear lesion		T	0008	20.1996	$1,391.27	.	$278.26
69020	Drain outer ear canal lesion		T	0006	1.4906	$102.67	.	$20.54
69090	Pierce earlobes		E					
69100	Biopsy of external ear		T	0251	3.5538	$244.77	.	$48.96
69105	Biopsy of external ear canal		T	0253	17.3388	$1,194.23	$282.29	$238.85
69110	Remove external ear partial		T	0021	18.0784	$1,245.17	.	$249.04
69120	Removal of external ear		T	0254	25.6472	$1,766.48	.	$353.30
69140	Remove ear canal lesion(s)		T	0254	25.6472	$1,766.48	.	$353.30
69145	Remove ear canal lesion(s)		T	0021	18.0784	$1,245.17	.	$249.04
69150	Extensive ear canal surgery		T	0252	7.9194	$545.46	$109.16	$109.10
69155	Extensive ear/neck surgery		C					
69200	Clear outer ear canal		X	0340	0.6712	$46.23	.	$9.25

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69205	Clear outer ear canal		T	0022	23.8986	$1,646.04	$354.45	$329.21
69210	Remove impacted ear wax		X	0340	0.6712	$46.23	.	$9.25
69220	Clean out mastoid cavity		T	0013	0.9103	$62.70	.	$12.54
69222	Clean out mastoid cavity		T	0253	17.3388	$1,194.23	$282.29	$238.85
69300	Revise external ear		T	0254	25.6472	$1,766.48	.	$353.30
69310	Rebuild outer ear canal		T	0256	44.6899	$3,078.06	.	$615.62
69320	Rebuild outer ear canal		T	0256	44.6899	$3,078.06	.	$615.62
69399	Outer ear surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61
69400	Inflate middle ear canal		T	0251	3.5538	$244.77	.	$48.96
69401	Inflate middle ear canal		T	0251	3.5538	$244.77	.	$48.96
69405	Catheterize middle ear canal		T	0252	7.9194	$545.46	$109.16	$109.10
69420	Incision of eardrum		T	0251	3.5538	$244.77	.	$48.96
69421	Incision of eardrum		T	0253	17.3388	$1,194.23	$282.29	$238.85
69424	Remove ventilating tube		T	0253	17.3388	$1,194.23	$282.29	$238.85
69433	Create eardrum opening		T	0252	7.9194	$545.46	$109.16	$109.10
69436	Create eardrum opening		T	0253	17.3388	$1,194.23	$282.29	$238.85
69440	Exploration of middle ear		T	0254	25.6472	$1,766.48	.	$353.30
69450	Eardrum revision		T	0256	44.6899	$3,078.06	.	$615.62
69501	Mastoidectomy		T	0256	44.6899	$3,078.06	.	$615.62
69502	Mastoidectomy		T	0254	25.6472	$1,766.48	.	$353.30
69505	Remove mastoid structures		T	0256	44.6899	$3,078.06	.	$615.62
69511	Extensive mastoid surgery		T	0256	44.6899	$3,078.06	.	$615.62
69530	Extensive mastoid surgery		T	0256	44.6899	$3,078.06	.	$615.62
69535	Remove part of temporal bone		C					
69540	Remove ear lesion		T	0253	17.3388	$1,194.23	$282.29	$238.85
69550	Remove ear lesion		T	0256	44.6899	$3,078.06	.	$615.62
69552	Remove ear lesion		T	0256	44.6899	$3,078.06	.	$615.62
69554	Remove ear lesion		C					
69601	Mastoid surgery revision		T	0256	44.6899	$3,078.06	.	$615.62
69602	Mastoid surgery revision		T	0256	44.6899	$3,078.06	.	$615.62
69603	Mastoid surgery revision		T	0256	44.6899	$3,078.06	.	$615.62
69604	Mastoid surgery revision		T	0256	44.6899	$3,078.06	.	$615.62
69605	Mastoid surgery revision		T	0256	44.6899	$3,078.06	.	$615.62
69610	Repair of eardrum		T	0254	25.6472	$1,766.48	.	$353.30
69620	Repair of eardrum		T	0254	25.6472	$1,766.48	.	$353.30
69631	Repair eardrum structures		T	0256	44.6899	$3,078.06	.	$615.62
69632	Rebuild eardrum structures		T	0256	44.6899	$3,078.06	.	$615.62
69633	Rebuild eardrum structures		T	0256	44.6899	$3,078.06	.	$615.62
69635	Repair eardrum structures		T	0256	44.6899	$3,078.06	.	$615.62

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69636	Rebuild eardrum structures		T	0256	44.6899	$3,078.06	.	$615.62
69637	Rebuild eardrum structures		T	0256	44.6899	$3,078.06	.	$615.62
69641	Revise middle ear & mastoid		T	0256	44.6899	$3,078.06	.	$615.62
69642	Revise middle ear & mastoid		T	0256	44.6899	$3,078.06	.	$615.62
69643	Revise middle ear & mastoid		T	0256	44.6899	$3,078.06	.	$615.62
69644	Revise middle ear & mastoid		T	0256	44.6899	$3,078.06	.	$615.62
69645	Revise middle ear & mastoid		T	0256	44.6899	$3,078.06	.	$615.62
69646	Revise middle ear & mastoid		T	0256	44.6899	$3,078.06	.	$615.62
69650	Release middle ear bone		T	0254	25.6472	$1,766.48	.	$353.30
69660	Revise middle ear bone		T	0256	44.6899	$3,078.06	.	$615.62
69661	Revise middle ear bone		T	0256	44.6899	$3,078.06	.	$615.62
69662	Revise middle ear bone		T	0256	44.6899	$3,078.06	.	$615.62
69666	Repair middle ear structures		T	0256	44.6899	$3,078.06	.	$615.62
69667	Repair middle ear structures		T	0256	44.6899	$3,078.06	.	$615.62
69670	Remove mastoid air cells		T	0256	44.6899	$3,078.06	.	$615.62
69676	Remove middle ear nerve		T	0256	44.6899	$3,078.06	.	$615.62
69700	Close mastoid fistula		T	0256	44.6899	$3,078.06	.	$615.62
69710	Implant/replace hearing aid		E					
69711	Remove/repair hearing aid		T	0256	44.6899	$3,078.06	.	$615.62
69714	Implant temple bone w/stimul		T	0425	124.8075	$8,596.24	.	$1,719.25
69715	Temple bne implnt w/stimulat		T	0425	124.8075	$8,596.24	.	$1,719.25
69717	Temple bone implant revision		T	0425	124.8075	$8,596.24	.	$1,719.25
69718	Revise temple bone implant		T	0425	124.8075	$8,596.24	.	$1,719.25
69720	Release facial nerve		T	0256	44.6899	$3,078.06	.	$615.62
69725	Release facial nerve		T	0256	44.6899	$3,078.06	.	$615.62
69740	Repair facial nerve		T	0256	44.6899	$3,078.06	.	$615.62
69745	Repair facial nerve		T	0256	44.6899	$3,078.06	.	$615.62
69799	Middle ear surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61
69801	Incise inner ear	NI	T	0253	17.3388	$1,194.23	$282.29	$238.85
69802	Incise inner ear	NI	T	0254	25.6472	$1,766.48	.	$353.30
69805	Explore inner ear		T	0256	44.6899	$3,078.06	.	$615.62
69806	Explore inner ear		T	0256	44.6899	$3,078.06	.	$615.62
69820	Establish inner ear window		T	0256	44.6899	$3,078.06	.	$615.62
69840	Revise inner ear window		T	0256	44.6899	$3,078.06	.	$615.62
69905	Remove inner ear		T	0256	44.6899	$3,078.06	.	$615.62
69910	Remove inner ear & mastoid		T	0256	44.6899	$3,078.06	.	$615.62
69915	Incise inner ear nerve		T	0256	44.6899	$3,078.06	.	$615.62
69930	Implant cochlear device		T	0259	450.9625	$31,060.49	$8,543.66	$6,212.10
69949	Inner ear surgery procedure		T	0250	1.1331	$78.04	$25.10	$15.61

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69950	Incise inner ear nerve		C					
69955	Release facial nerve		T	0256	44.6899	$3,078.06	.	$615.62
69960	Release inner ear canal		T	0256	44.6899	$3,078.06	.	$615.62
69970	Remove inner ear lesion		T	0256	44.6899	$3,078.06	.	$615.62
69979	Temporal bone surgery		T	0250	1.1331	$78.04	$25.10	$15.61
69990	Microsurgery add-on		N					
70010	Contrast x-ray of brain		Q2	0274	7.2463	$499.10	.	$99.82
70015	Contrast x-ray of brain		Q2	0274	7.2463	$499.10	.	$99.82
70030	X-ray eye for foreign body		X	0260	0.6539	$45.04	.	$9.01
70100	X-ray exam of jaw		X	0260	0.6539	$45.04	.	$9.01
70110	X-ray exam of jaw		X	0260	0.6539	$45.04	.	$9.01
70120	X-ray exam of mastoids		X	0260	0.6539	$45.04	.	$9.01
70130	X-ray exam of mastoids		X	0260	0.6539	$45.04	.	$9.01
70134	X-ray exam of middle ear		X	0261	1.1014	$75.86	.	$15.18
70140	X-ray exam of facial bones		X	0260	0.6539	$45.04	.	$9.01
70150	X-ray exam of facial bones		X	0260	0.6539	$45.04	.	$9.01
70160	X-ray exam of nasal bones		X	0260	0.6539	$45.04	.	$9.01
70170	X-ray exam of tear duct		Q2	0263	3.3387	$229.96	.	$46.00
70190	X-ray exam of eye sockets		X	0260	0.6539	$45.04	.	$9.01
70200	X-ray exam of eye sockets		X	0260	0.6539	$45.04	.	$9.01
70210	X-ray exam of sinuses		X	0260	0.6539	$45.04	.	$9.01
70220	X-ray exam of sinuses		X	0260	0.6539	$45.04	.	$9.01
70240	X-ray exam pituitary saddle		X	0260	0.6539	$45.04	.	$9.01
70250	X-ray exam of skull		X	0260	0.6539	$45.04	.	$9.01
70260	X-ray exam of skull		X	0261	1.1014	$75.86	.	$15.18
70300	X-ray exam of teeth		X	0262	0.4426	$30.48	.	$6.10
70310	X-ray exam of teeth		X	0262	0.4426	$30.48	.	$6.10
70320	Full mouth x-ray of teeth		X	0262	0.4426	$30.48	.	$6.10
70328	X-ray exam of jaw joint		X	0260	0.6539	$45.04	.	$9.01
70330	X-ray exam of jaw joints		X	0260	0.6539	$45.04	.	$9.01
70332	X-ray exam of jaw joint		Q2	0275	3.9933	$275.04	$68.90	$55.01
70336	Magnetic image jaw joint		Q3	0336	4.9789	$342.93	$135.13	$68.59
70350	X-ray head for orthodontia		X	0260	0.6539	$45.04	.	$9.01
70355	Panoramic x-ray of jaws	CH	X	0262	0.4426	$30.48	.	$6.10
70360	X-ray exam of neck		X	0260	0.6539	$45.04	.	$9.01
70370	Throat x-ray & fluoroscopy		X	0272	1.2123	$83.50	$30.47	$16.70
70371	Speech evaluation complex		X	0272	1.2123	$83.50	$30.47	$16.70
70373	Contrast x-ray of larynx		Q2	0263	3.3387	$229.96	.	$46.00
70380	X-ray exam of salivary gland		X	0260	0.6539	$45.04	.	$9.01

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70390	X-ray exam of salivary duct		Q2	0263	3.3387	$229.96	.	$46.00
70450	Ct head/brain w/o dye		Q3	0332	2.8145	$193.85	$74.95	$38.77
70460	Ct head/brain w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
70470	Ct head/brain w/o & w/dye		Q3	0333	4.8528	$334.24	$116.13	$66.85
70480	Ct orbit/ear/fossa w/o dye		Q3	0332	2.8145	$193.85	$74.95	$38.77
70481	Ct orbit/ear/fossa w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
70482	Ct orbit/ear/fossa w/o&w/dye		Q3	0333	4.8528	$334.24	$116.13	$66.85
70486	Ct maxillofacial w/o dye		Q3	0332	2.8145	$193.85	$74.95	$38.77
70487	Ct maxillofacial w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
70488	Ct maxillofacial w/o & w/dye		Q3	0333	4.8528	$334.24	$116.13	$66.85
70490	Ct soft tissue neck w/o dye		Q3	0332	2.8145	$193.85	$74.95	$38.77
70491	Ct soft tissue neck w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
70492	Ct sft tsue nck w/o & w/dye		Q3	0333	4.8528	$334.24	$116.13	$66.85
70496	Ct angiography head		Q3	0662	4.9151	$338.53	$114.37	$67.71
70498	Ct angiography neck		Q3	0662	4.9151	$338.53	$114.37	$67.71
70540	Mri orbit/face/neck w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
70542	Mri orbit/face/neck w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
70543	Mri orbt/fac/nck w/o & w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
70544	Mr angiography head w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
70545	Mr angiography head w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
70546	Mr angiograph head w/o&w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
70547	Mr angiography neck w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
70548	Mr angiography neck w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
70549	Mr angiograph neck w/o&w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
70551	Mri brain w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
70552	Mri brain w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
70553	Mri brain w/o & w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
70554	Fmri brain by tech		Q3	0336	4.9789	$342.93	$135.13	$68.59
70555	Fmri brain by phys/psych		S	0336	4.9789	$342.93	$135.13	$68.59
70557	Mri brain w/o dye		S	0336	4.9789	$342.93	$135.13	$68.59
70558	Mri brain w/dye		S	0284	6.3444	$436.98	$146.85	$87.40
70559	Mri brain w/o & w/dye		S	0337	7.7472	$533.60	$197.64	$106.72
71010	Chest x-ray	CH	Q3	0260	0.6539	$45.04	.	$9.01
71015	Chest x-ray	CH	Q3	0260	0.6539	$45.04	.	$9.01
71020	Chest x-ray	CH	Q3	0260	0.6539	$45.04	.	$9.01
71021	Chest x-ray		X	0260	0.6539	$45.04	.	$9.01
71022	Chest x-ray		X	0260	0.6539	$45.04	.	$9.01
71023	Chest x-ray and fluoroscopy		X	0272	1.2123	$83.50	$30.47	$16.70

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71030	Chest x-ray		X	0260	0.6539	$45.04	.	$9.01
71034	Chest x-ray and fluoroscopy		X	0272	1.2123	$83.50	$30.47	$16.70
71035	Chest x-ray		X	0260	0.6539	$45.04	.	$9.01
71040	Contrast x-ray of bronchi		Q2	0263	3.3387	$229.96	.	$46.00
71060	Contrast x-ray of bronchi		Q2	0263	3.3387	$229.96	.	$46.00
71090	X-ray & pacemaker insertion		N					
71100	X-ray exam of ribs		X	0260	0.6539	$45.04	.	$9.01
71101	X-ray exam of ribs/chest		X	0260	0.6539	$45.04	.	$9.01
71110	X-ray exam of ribs		X	0260	0.6539	$45.04	.	$9.01
71111	X-ray exam of ribs/chest		X	0261	1.1014	$75.86	.	$15.18
71120	X-ray exam of breastbone		X	0260	0.6539	$45.04	.	$9.01
71130	X-ray exam of breastbone		X	0260	0.6539	$45.04	.	$9.01
71250	Ct thorax w/o dye		Q3	0332	2.8145	$193.85	$74.95	$38.77
71260	Ct thorax w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
71270	Ct thorax w/o & w/dye		Q3	0333	4.8528	$334.24	$116.13	$66.85
71275	Ct angiography chest		Q3	0662	4.9151	$338.53	$114.37	$67.71
71550	Mri chest w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
71551	Mri chest w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
71552	Mri chest w/o & w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
71555	Mri angio chest w or w/o dye		B					
72010	X-ray exam of spine		X	0261	1.1014	$75.86	.	$15.18
72020	X-ray exam of spine		X	0260	0.6539	$45.04	.	$9.01
72040	X-ray exam of neck spine		X	0260	0.6539	$45.04	.	$9.01
72050	X-ray exam of neck spine		X	0261	1.1014	$75.86	.	$15.18
72052	X-ray exam of neck spine		X	0261	1.1014	$75.86	.	$15.18
72069	X-ray exam of trunk spine		X	0260	0.6539	$45.04	.	$9.01
72070	X-ray exam of thoracic spine		X	0260	0.6539	$45.04	.	$9.01
72072	X-ray exam of thoracic spine		X	0260	0.6539	$45.04	.	$9.01
72074	X-ray exam of thoracic spine		X	0260	0.6539	$45.04	.	$9.01
72080	X-ray exam of trunk spine		X	0260	0.6539	$45.04	.	$9.01
72090	X-ray exam of trunk spine		X	0261	1.1014	$75.86	.	$15.18
72100	X-ray exam of lower spine		X	0260	0.6539	$45.04	.	$9.01
72110	X-ray exam of lower spine		X	0261	1.1014	$75.86	.	$15.18
72114	X-ray exam of lower spine		X	0261	1.1014	$75.86	.	$15.18
72120	X-ray exam of lower spine	CH	X	0260	0.6539	$45.04	.	$9.01
72125	Ct neck spine w/o dye		Q3	0332	2.8145	$193.85	$74.95	$38.77
72126	Ct neck spine w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
72127	Ct neck spine w/o & w/dye		Q3	0333	4.8528	$334.24	$116.13	$66.85
72128	Ct chest spine w/o dye		Q3	0332	2.8145	$193.85	$74.95	$38.77

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72129	Ct chest spine w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
72130	Ct chest spine w/o & w/dye		Q3	0333	4.8528	$334.24	$116.13	$66.85
72131	Ct lumbar spine w/o dye		Q3	0332	2.8145	$193.85	$74.95	$38.77
72132	Ct lumbar spine w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
72133	Ct lumbar spine w/o & w/dye		Q3	0333	4.8528	$334.24	$116.13	$66.85
72141	Mri neck spine w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
72142	Mri neck spine w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
72146	Mri chest spine w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
72147	Mri chest spine w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
72148	Mri lumbar spine w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
72149	Mri lumbar spine w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
72156	Mri neck spine w/o & w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
72157	Mri chest spine w/o & w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
72158	Mri lumbar spine w/o & w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
72159	Mr angio spine w/o&w/dye		B					
72170	X-ray exam of pelvis		X	0260	0.6539	$45.04	.	$9.01
72190	X-ray exam of pelvis		X	0260	0.6539	$45.04	.	$9.01
72191	Ct angiograph pelv w/o&w/dye		Q3	0662	4.9151	$338.53	$114.37	$67.71
72192	Ct pelvis w/o dye		Q3	0332	2.8145	$193.85	$74.95	$38.77
72193	Ct pelvis w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
72194	Ct pelvis w/o & w/dye		Q3	0333	4.8528	$334.24	$116.13	$66.85
72195	Mri pelvis w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
72196	Mri pelvis w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
72197	Mri pelvis w/o & w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
72198	Mr angio pelvis w/o & w/dye		B					
72200	X-ray exam sacroiliac joints		X	0260	0.6539	$45.04	.	$9.01
72202	X-ray exam sacroiliac joints		X	0260	0.6539	$45.04	.	$9.01
72220	X-ray exam of tailbone		X	0260	0.6539	$45.04	.	$9.01
72240	Contrast x-ray of neck spine		Q2	0274	7.2463	$499.10	.	$99.82
72255	Contrast x-ray thorax spine		Q2	0274	7.2463	$499.10	.	$99.82
72265	Contrast x-ray lower spine		Q2	0274	7.2463	$499.10	.	$99.82
72270	Contrast x-ray spine		Q2	0274	7.2463	$499.10	.	$99.82
72275	Epidurography		N					
72285	X-ray c/t spine disk		Q2	0388	24.2795	$1,672.27	.	$334.46
72291	Perq verte/sacroplsty fluor		N					
72292	Perq verte/sacroplsty ct		N					
72295	X-ray of lower spine disk		Q2	0388	24.2795	$1,672.27		$334.46
73000	X-ray exam of collar bone		X	0260	0.6539	$45.04	.	$9.01
73010	X-ray exam of shoulder blade		X	0260	0.6539	$45.04	.	$9.01

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73020	X-ray exam of shoulder		X	0260	0.6539	$45.04	.	$9.01
73030	X-ray exam of shoulder		X	0260	0.6539	$45.04	.	$9.01
73040	Contrast x-ray of shoulder		Q2	0275	3.9933	$275.04	$68.90	$55.01
73050	X-ray exam of shoulders		X	0260	0.6539	$45.04	.	$9.01
73060	X-ray exam of humerus		X	0260	0.6539	$45.04	.	$9.01
73070	X-ray exam of elbow		X	0260	0.6539	$45.04	.	$9.01
73080	X-ray exam of elbow		X	0260	0.6539	$45.04	.	$9.01
73085	Contrast x-ray of elbow		Q2	0275	3.9933	$275.04	$68.90	$55.01
73090	X-ray exam of forearm		X	0260	0.6539	$45.04	.	$9.01
73092	X-ray exam of arm infant		X	0260	0.6539	$45.04	.	$9.01
73100	X-ray exam of wrist		X	0260	0.6539	$45.04	.	$9.01
73110	X-ray exam of wrist		X	0260	0.6539	$45.04	.	$9.01
73115	Contrast x-ray of wrist		Q2	0275	3.9933	$275.04	$68.90	$55.01
73120	X-ray exam of hand		X	0260	0.6539	$45.04	.	$9.01
73130	X-ray exam of hand		X	0260	0.6539	$45.04	.	$9.01
73140	X-ray exam of finger(s)		X	0260	0.6539	$45.04	.	$9.01
73200	Ct upper extremity w/o dye		Q3	0332	2.8145	$193.85	$74.95	$38.77
73201	Ct upper extremity w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
73202	Ct uppr extremity w/o&w/dye		Q3	0333	4.8528	$334.24	$116.13	$66.85
73206	Ct angio upr extrm w/o&w/dye		Q3	0662	4.9151	$338.53	$114.37	$67.71
73218	Mri upper extremity w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
73219	Mri upper extremity w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
73220	Mri uppr extremity w/o&w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
73221	Mri joint upr extrem w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
73222	Mri joint upr extrem w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
73223	Mri joint upr extr w/o&w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
73225	Mr angio upr extr w/o&w/dye		B					
73500	X-ray exam of hip		X	0260	0.6539	$45.04	.	$9.01
73510	X-ray exam of hip		X	0260	0.6539	$45.04	.	$9.01
73520	X-ray exam of hips	CH	X	0260	0.6539	$45.04	.	$9.01
73525	Contrast x-ray of hip		Q2	0275	3.9933	$275.04	$68.90	$55.01
73530	X-ray exam of hip		N					
73540	X-ray exam of pelvis & hips		X	0260	0.6539	$45.04	.	$9.01
73542	X-ray exam sacroiliac joint		Q2	0275	3.9933	$275.04	$68.90	$55.01
73550	X-ray exam of thigh		X	0260	0.6539	$45.04	.	$9.01
73560	X-ray exam of knee 1 or 2		X	0260	0.6539	$45.04	.	$9.01
73562	X-ray exam of knee 3		X	0260	0.6539	$45.04	.	$9.01
73564	X-ray exam knee 4 or more		X	0260	0.6539	$45.04	.	$9.01
73565	X-ray exam of knees		X	0260	0.6539	$45.04	.	$9.01

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73580	Contrast x-ray of knee joint		Q2	0275	3.9933	$275.04	$68.90	$55.01
73590	X-ray exam of lower leg		X	0260	0.6539	$45.04	.	$9.01
73592	X-ray exam of leg infant		X	0260	0.6539	$45.04	.	$9.01
73600	X-ray exam of ankle		X	0260	0.6539	$45.04	.	$9.01
73610	X-ray exam of ankle		X	0260	0.6539	$45.04	.	$9.01
73615	Contrast x-ray of ankle		Q2	0275	3.9933	$275.04	$68.90	$55.01
73620	X-ray exam of foot		X	0260	0.6539	$45.04	.	$9.01
73630	X-ray exam of foot		X	0260	0.6539	$45.04	.	$9.01
73650	X-ray exam of heel		X	0260	0.6539	$45.04	.	$9.01
73660	X-ray exam of toe(s)		X	0260	0.6539	$45.04	.	$9.01
73700	Ct lower extremity w/o dye		Q3	0332	2.8145	$193.85	$74.95	$38.77
73701	Ct lower extremity w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
73702	Ct lwr extremity w/o&w/dye		Q3	0333	4.8528	$334.24	$116.13	$66.85
73706	Ct angio lwr extr w/o&w/dye		Q3	0662	4.9151	$338.53	$114.37	$67.71
73718	Mri lower extremity w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
73719	Mri lower extremity w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
73720	Mri lwr extremity w/o&w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
73721	Mri jnt of lwr extre w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
73722	Mri joint of lwr extr w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
73723	Mri joint lwr extr w/o&w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
73725	Mr ang lwr ext w or w/o dye		B					
74000	X-ray exam of abdomen		X	0260	0.6539	$45.04	.	$9.01
74010	X-ray exam of abdomen		X	0260	0.6539	$45.04	.	$9.01
74020	X-ray exam of abdomen		X	0260	0.6539	$45.04	.	$9.01
74022	X-ray exam series abdomen		X	0261	1.1014	$75.86	.	$15.18
74150	Ct abdomen w/o dye		Q3	0332	2.8145	$193.85	$74.95	$38.77
74160	Ct abdomen w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
74170	Ct abdomen w/o & w/dye		Q3	0333	4.8528	$334.24	$116.13	$66.85
74175	Ct angio abdom w/o & w/dye		Q3	0662	4.9151	$338.53	$114.37	$67.71
74176	Ct abd & pelvis w/o contrast	NI	Q3	0332	2.8145	$193.85	$74.95	$38.77
74177	Ct abdomen&pelvis w/contrast	NI	Q3	0283	4.3529	$299.81	$96.62	$59.97
74178	Ct abd&pelv 1+ section/regns	NI	Q3	0333	4.8528	$334.24	$116.13	$66.85
74181	Mri abdomen w/o dye		Q3	0336	4.9789	$342.93	$135.13	$68.59
74182	Mri abdomen w/dye		Q3	0284	6.3444	$436.98	$146.85	$87.40
74183	Mri abdomen w/o & w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
74185	Mri angio abdom w orw/o dye		B					
74190	X-ray exam of peritoneum		Q2	0263	3.3387	$229.96	.	$46.00
74210	Contrst x-ray exam of throat		S	0276	1.2591	$86.72	$34.43	$17.35
74220	Contrast x-ray esophagus		S	0276	1.2591	$86.72	$34.43	$17.35

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74230	Cine/vid x-ray throat/esoph		S	0276	1.2591	$86.72	$34.43	$17.35
74235	Remove esophagus obstruction		N					
74240	X-ray exam upper gi tract		S	0276	1.2591	$86.72	$34.43	$17.35
74241	X-ray exam upper gi tract		S	0276	1.2591	$86.72	$34.43	$17.35
74245	X-ray exam upper gi tract		S	0277	2.0614	$141.98	$53.90	$28.40
74246	Contrst x-ray uppr gi tract		S	0276	1.2591	$86.72	$34.43	$17.35
74247	Contrst x-ray uppr gi tract		S	0276	1.2591	$86.72	$34.43	$17.35
74249	Contrst x-ray uppr gi tract		S	0277	2.0614	$141.98	$53.90	$28.40
74250	X-ray exam of small bowel		S	0276	1.2591	$86.72	$34.43	$17.35
74251	X-ray exam of small bowel		S	0277	2.0614	$141.98	$53.90	$28.40
74260	X-ray exam of small bowel		S	0276	1.2591	$86.72	$34.43	$17.35
74261	Ct colonography dx		Q3	0332	2.8145	$193.85	$74.95	$38.77
74262	Ct colonography dx w/dye		Q3	0283	4.3529	$299.81	$96.62	$59.97
74263	Ct colonography screening		E					
74270	Contrast x-ray exam of colon		S	0276	1.2591	$86.72	$34.43	$17.35
74280	Contrast x-ray exam of colon		S	0277	2.0614	$141.98	$53.90	$28.40
74283	Contrast x-ray exam of colon		S	0276	1.2591	$86.72	$34.43	$17.35
74290	Contrast x-ray gallbladder		S	0276	1.2591	$86.72	$34.43	$17.35
74291	Contrast x-rays gallbladder		S	0276	1.2591	$86.72	$34.43	$17.35
74300	X-ray bile ducts/pancreas		N					
74301	X-rays at surgery add-on		N					
74305	X-ray bile ducts/pancreas		Q2	0263	3.3387	$229.96	.	$46.00
74320	Contrast x-ray of bile ducts		Q2	0317	5.9108	$407.11	.	$81.43
74327	X-ray bile stone removal		N					
74328	X-ray bile duct endoscopy		N					
74329	X-ray for pancreas endoscopy		N					
74330	X-ray bile/panc endoscopy		N					
74340	X-ray guide for GI tube		N					
74355	X-ray guide intestinal tube		N					
74360	X-ray guide gi dilation		N					
74363	X-ray bile duct dilation		N					
74400	Contrst x-ray urinary tract		S	0278	2.5571	$176.12	$58.44	$35.23
74410	Contrst x-ray urinary tract		S	0278	2.5571	$176.12	$58.44	$35.23
74415	Contrst x-ray urinary tract		S	0278	2.5571	$176.12	$58.44	$35.23
74420	Contrst x-ray urinary tract		S	0278	2.5571	$176.12	$58.44	$35.23
74425	Contrst x-ray urinary tract		Q2	0278	2.5571	$176.12	$58.44	$35.23
74430	Contrast x-ray bladder		Q2	0278	2.5571	$176.12	$58.44	$35.23
74440	X-ray male genital tract		Q2	0278	2.5571	$176.12	$58.44	$35.23

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74445	X-ray exam of penis		Q2	0278	2.5571	$176.12	$58.44	$35.23
74450	X-ray urethra/bladder		Q2	0278	2.5571	$176.12	$58.44	$35.23
74455	X-ray urethra/bladder		Q2	0278	2.5571	$176.12	$58.44	$35.23
74470	X-ray exam of kidney lesion		Q2	0263	3.3387	$229.96	.	$46.00
74475	X-ray control cath insert		Q2	0161	17.5738	$1,210.41	.	$242.09
74480	X-ray control cath insert		Q2	0161	17.5738	$1,210.41	.	$242.09
74485	X-ray guide gu dilation		Q2	0161	17.5738	$1,210.41	.	$242.09
74710	X-ray measurement of pelvis		X	0261	1.1014	$75.86	.	$15.18
74740	X-ray female genital tract		Q2	0263	3.3387	$229.96	.	$46.00
74742	X-ray fallopian tube		N					
74775	X-ray exam of perineum		S	0278	2.5571	$176.12	$58.44	$35.23
75557	Cardiac mri for morph		Q3	0336	4.9789	$342.93	$135.13	$68.59
75559	Cardiac mri w/stress img		Q3	0336	4.9789	$342.93	$135.13	$68.59
75561	Cardiac mri for morph w/dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
75563	Card mri w/stress img & dye		Q3	0337	7.7472	$533.60	$197.64	$106.72
75565	Card mri veloc flow mapping		N					
75571	Ct hrt w/o dye w/ca test		X	0340	0.6712	$46.23	.	$9.25
75572	Ct hrt w/3d image		S	0383	3.7293	$256.86	.	$51.38
75573	Ct hrt w/3d image congen		S	0383	3.7293	$256.86	.	$51.38
75574	Ct angio hrt w/3d image		S	0383	3.7293	$256.86	.	$51.38
75600	Contrast x-ray exam of aorta		Q2	0279	29.4238	$2,026.59	.	$405.32
75605	Contrast x-ray exam of aorta		Q2	0279	29.4238	$2,026.59	.	$405.32
75625	Contrast x-ray exam of aorta		Q2	0279	29.4238	$2,026.59	.	$405.32
75630	X-ray aorta leg arteries		Q2	0279	29.4238	$2,026.59	.	$405.32
75635	Ct angio abdominal arteries		Q2	0662	4.9151	$338.53	$114.37	$67.71
75650	Artery x-rays head & neck		Q2	0280	47.7637	$3,289.77	.	$657.96
75658	Artery x-rays arm		Q2	0279	29.4238	$2,026.59	.	$405.32
75660	Artery x-rays head & neck		Q2	0280	47.7637	$3,289.77	.	$657.96
75662	Artery x-rays head & neck		Q2	0280	47.7637	$3,289.77	.	$657.96
75665	Artery x-rays head & neck		Q2	0279	29.4238	$2,026.59	.	$405.32
75671	Artery x-rays head & neck		Q2	0280	47.7637	$3,289.77	.	$657.96
75676	Artery x-rays neck		Q2	0279	29.4238	$2,026.59	.	$405.32
75680	Artery x-rays neck		Q2	0279	29.4238	$2,026.59	.	$405.32
75685	Artery x-rays spine		Q2	0279	29.4238	$2,026.59	.	$405.32
75705	Artery x-rays spine		Q2	0279	29.4238	$2,026.59	.	$405.32
75710	Artery x-rays arm/leg		Q2	0279	29.4238	$2,026.59	.	$405.32
75716	Artery x-rays arms/legs		Q2	0279	29.4238	$2,026.59	.	$405.32
75722	Artery x-rays kidney		Q2	0279	29.4238	$2,026.59	.	$405.32
75724	Artery x-rays kidneys		Q2	0279	29.4238	$2,026.59	.	$405.32

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75726	Artery x-rays abdomen		Q2	0279	29.4238	$2,026.59	.	$405.32
75731	Artery x-rays adrenal gland		Q2	0279	29.4238	$2,026.59	.	$405.32
75733	Artery x-rays adrenals		Q2	0279	29.4238	$2,026.59	.	$405.32
75736	Artery x-rays pelvis		Q2	0279	29.4238	$2,026.59	.	$405.32
75741	Artery x-rays lung		Q2	0279	29.4238	$2,026.59	.	$405.32
75743	Artery x-rays lungs		Q2	0279	29.4238	$2,026.59	.	$405.32
75746	Artery x-rays lung		Q2	0668	10.4347	$718.70	.	$143.74
75756	Artery x-rays chest		Q2	0668	10.4347	$718.70	.	$143.74
75774	Artery x-ray each vessel		N					
75791	Av dialysis shunt imaging		Q2	0676	2.3474	$161.68	.	$32.34
75801	Lymph vessel x-ray arm/leg		Q2	0317	5.9108	$407.11	.	$81.43
75803	Lymph vessel x-ray arms/legs		Q2	0317	5.9108	$407.11	.	$81.43
75805	Lymph vessel x-ray trunk		Q2	0317	5.9108	$407.11	.	$81.43
75807	Lymph vessel x-ray trunk		Q2	0317	5.9108	$407.11	.	$81.43
75809	Nonvascular shunt x-ray		Q2	0261	1.1014	$75.86	.	$15.18
75810	Vein x-ray spleen/liver		Q2	0279	29.4238	$2,026.59	.	$405.32
75820	Vein x-ray arm/leg		Q2	0668	10.4347	$718.70	.	$143.74
75822	Vein x-ray arms/legs		Q2	0668	10.4347	$718.70	.	$143.74
75825	Vein x-ray trunk		Q2	0279	29.4238	$2,026.59	.	$405.32
75827	Vein x-ray chest		Q2	0668	10.4347	$718.70	.	$143.74
75831	Vein x-ray kidney		Q2	0279	29.4238	$2,026.59	.	$405.32
75833	Vein x-ray kidneys		Q2	0279	29.4238	$2,026.59	.	$405.32
75840	Vein x-ray adrenal gland		Q2	0279	29.4238	$2,026.59	.	$405.32
75842	Vein x-ray adrenal glands		Q2	0279	29.4238	$2,026.59	.	$405.32
75860	Vein x-ray neck		Q2	0668	10.4347	$718.70	.	$143.74
75870	Vein x-ray skull		Q2	0668	10.4347	$718.70	.	$143.74
75872	Vein x-ray skull		Q2	0668	10.4347	$718.70	.	$143.74
75880	Vein x-ray eye socket		Q2	0668	10.4347	$718.70	.	$143.74
75885	Vein x-ray liver		Q2	0279	29.4238	$2,026.59	.	$405.32
75887	Vein x-ray liver		Q2	0668	10.4347	$718.70	.	$143.74
75889	Vein x-ray liver		Q2	0279	29.4238	$2,026.59	.	$405.32
75891	Vein x-ray liver		Q2	0279	29.4238	$2,026.59	.	$405.32
75893	Venous sampling by catheter		Q2	0279	29.4238	$2,026.59	.	$405.32
75894	X-rays transcath therapy		N					
75896	X-rays transcath therapy		N					
75898	Follow-up angiography		Q1	0261	1.1014	$75.86	.	$15.18
75900	Intravascular cath exchange		C					
75901	Remove cva device obstruct		N					
75902	Remove cva lumen obstruct		N					

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75940	X-ray placement vein filter		N					
75945	Intravascular us		Q2	0267	2.2212	$152.99	$59.84	$30.60
75946	Intravascular us add-on		N					
75952	Endovasc repair abdom aorta		C					
75953	Abdom aneurysm endovas rpr		C					
75954	Iliac aneurysm endovas rpr		C					
75956	Xray endovasc thor ao repr		C					
75957	Xray endovasc thor ao repr		C					
75958	Xray place prox ext thor ao		C					
75959	Xray place dist ext thor ao		C					
75960	Transcath iv stent rs&i		N					
75961	Retrieval broken catheter		N					
75962	Repair arterial blockage		Q2	0083	54.8838	$3,780.18	.	$756.04
75964	Repair artery blockage each		N					
75966	Repair arterial blockage		Q2	0083	54.8838	$3,780.18	.	$756.04
75968	Repair artery blockage each		N					
75970	Vascular biopsy		N					
75978	Repair venous blockage		Q2	0093	36.4868	$2,513.06	.	$502.62
75980	Contrast xray exam bile duct		N					
75982	Contrast xray exam bile duct		N					
75984	Xray control catheter change		N					
75989	Abscess drainage under x-ray		N					
75992	Atherectomy, x-ray exam	CH	D					
75993	Atherectomy, x-ray exam	CH	D					
75994	Atherectomy, x-ray exam	CH	D					
75995	Atherectomy, x-ray exam	CH	D					
75996	Atherectomy, x-ray exam	CH	D					
76000	Fluoroscope examination		Q1	0272	1.2123	$83.50	$30.47	$16.70
76001	Fluoroscope exam extensive		N					
76010	X-ray nose to rectum		X	0260	0.6539	$45.04	.	$9.01
76080	X-ray exam of fistula		Q2	0263	3.3387	$229.96	.	$46.00
76098	X-ray exam breast specimen		Q2	0317	5.9108	$407.11	.	$81.43
76100	X-ray exam of body section		X	0261	1.1014	$75.86	.	$15.18
76101	Complex body section x-ray		X	0263	3.3387	$229.96	.	$46.00
76102	Complex body section x-rays		X	0263	3.3387	$229.96	.	$46.00
76120	Cine/video x-rays		X	0272	1.2123	$83.50	$30.47	$16.70
76125	Cine/video x-rays add-on		N					
76140	X-ray consultation		E					
76150	X-ray exam, dry process	CH	D					

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76350	Special x-ray contrast study	CH	D					
76376	3d render w/o postprocess		N					
76377	3d rendering w/postprocess		N					
76380	CAT scan follow-up study		S	0282	1.6478	$113.49	$37.81	$22.70
76390	Mr spectroscopy		E					
76496	Fluoroscopic procedure		X	0272	1.2123	$83.50	$30.47	$16.70
76497	Ct procedure		S	0282	1.6478	$113.49	$37.81	$22.70
76498	Mri procedure		S	0336	4.9789	$342.93	$135.13	$68.59
76499	Radiographic procedure		X	0260	0.6539	$45.04	.	$9.01
76506	Echo exam of head		S	0265	0.9038	$62.25	$22.26	$12.45
76510	Ophth us b & quant a		T	0232	2.5480	$175.50	$42.27	$35.10
76511	Ophth us quant a only		S	0266	1.3979	$96.28	$37.23	$19.26
76512	Ophth us b w/non-quant a		S	0266	1.3979	$96.28	$37.23	$19.26
76513	Echo exam of eye water bath		S	0266	1.3979	$96.28	$37.23	$19.26
76514	Echo exam of eye thickness		X	0035	0.2674	$18.42	.	$3.69
76516	Echo exam of eye		S	0265	0.9038	$62.25	$22.26	$12.45
76519	Echo exam of eye		S	0266	1.3979	$96.28	$37.23	$19.26
76529	Echo exam of eye		S	0265	0.9038	$62.25	$22.26	$12.45
76536	Us exam of head and neck		S	0266	1.3979	$96.28	$37.23	$19.26
76604	Us exam chest		Q3	0265	0.9038	$62.25	$22.26	$12.45
76645	Us exam breast(s)		S	0265	0.9038	$62.25	$22.26	$12.45
76700	Us exam abdom complete		Q3	0266	1.3979	$96.28	$37.23	$19.26
76705	Echo exam of abdomen		Q3	0266	1.3979	$96.28	$37.23	$19.26
76770	Us exam abdo back wall comp		Q3	0266	1.3979	$96.28	$37.23	$19.26
76775	Us exam abdo back wall lim		Q3	0266	1.3979	$96.28	$37.23	$19.26
76776	Us exam k transpl w/doppler		Q3	0266	1.3979	$96.28	$37.23	$19.26
76800	Us exam spinal canal		S	0266	1.3979	$96.28	$37.23	$19.26
76801	Ob us < 14 wks single fetus		S	0266	1.3979	$96.28	$37.23	$19.26
76802	Ob us < 14 wks addl fetus		S	0265	0.9038	$62.25	$22.26	$12.45
76805	Ob us >/= 14 wks sngl fetus		S	0266	1.3979	$96.28	$37.23	$19.26
76810	Ob us >/= 14 wks addl fetus		S	0266	1.3979	$96.28	$37.23	$19.26
76811	Ob us detailed sngl fetus		S	0267	2.2212	$152.99	$59.84	$30.60
76812	Ob us detailed addl fetus		S	0265	0.9038	$62.25	$22.26	$12.45
76813	Ob us nuchal meas 1 gest		S	0265	0.9038	$62.25	$22.26	$12.45
76814	Ob us nuchal meas add-on		S	0265	0.9038	$62.25	$22.26	$12.45
76815	Ob us limited fetus(s)		S	0265	0.9038	$62.25	$22.26	$12.45
76816	Ob us follow-up per fetus		S	0265	0.9038	$62.25	$22.26	$12.45
76817	Transvaginal us obstetric		S	0265	0.9038	$62.25	$22.26	$12.45
76818	Fetal biophys profile w/nst		S	0266	1.3979	$96.28	$37.23	$19.26

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76819	Fetal biophys profil w/o nst		S	0266	1.3979	$96.28	$37.23	$19.26
76820	Umbilical artery echo		S	0265	0.9038	$62.25	$22.26	$12.45
76821	Middle cerebral artery echo		S	0265	0.9038	$62.25	$22.26	$12.45
76825	Echo exam of fetal heart		S	0270	8.1617	$562.15	$133.61	$112.43
76826	Echo exam of fetal heart		S	0269	5.8423	$402.39	.	$80.48
76827	Echo exam of fetal heart		S	0265	0.9038	$62.25	$22.26	$12.45
76828	Echo exam of fetal heart		S	0265	0.9038	$62.25	$22.26	$12.45
76830	Transvaginal us non-ob		S	0266	1.3979	$96.28	$37.23	$19.26
76831	Echo exam uterus		Q3	0267	2.2212	$152.99	$59.84	$30.60
76856	Us exam pelvic complete		Q3	0266	1.3979	$96.28	$37.23	$19.26
76857	Us exam pelvic limited		Q3	0265	0.9038	$62.25	$22.26	$12.45
76870	Us exam scrotum		Q3	0266	1.3979	$96.28	$37.23	$19.26
76872	Us transrectal		S	0266	1.3979	$96.28	$37.23	$19.26
76873	Echograp trans r pros study		S	0266	1.3979	$96.28	$37.23	$19.26
76880	Us exam, extremity	CH	D					
76881	Us xtr non-vasc complete	NI	S	0266	1.3979	$96.28	$37.23	$19.26
76882	Us xtr non-vasc lmtd	NI	S	0265	0.9038	$62.25	$22.26	$12.45
76885	Us exam infant hips dynamic		S	0265	0.9038	$62.25	$22.26	$12.45
76886	Us exam infant hips static		S	0265	0.9038	$62.25	$22.26	$12.45
76930	Echo guide cardiocentesis		N					
76932	Echo guide for heart biopsy		N					
76936	Echo guide for artery repair		S	0096	1.5460	$106.48	$36.86	$21.30
76937	Us guide vascular access		N					
76940	Us guide tissue ablation		N					
76941	Echo guide for transfusion		N					
76942	Echo guide for biopsy		N					
76945	Echo guide villus sampling		N					
76946	Echo guide for amniocentesis		N					
76948	Echo guide ova aspiration		N					
76950	Echo guidance radiotherapy		N					
76965	Echo guidance radiotherapy		N					
76970	Ultrasound exam follow-up		S	0265	0.9038	$62.25	$22.26	$12.45
76975	GI endoscopic ultrasound		Q2	0267	2.2212	$152.99	$59.84	$30.60
76977	Us bone density measure		X	0340	0.6712	$46.23	$0.00	$0.00
76998	Us guide intraop		N					
76999	Echo examination procedure		S	0265	0.9038	$62.25	$22.26	$12.45
77001	Fluoroguide for vein device		N					
77002	Needle localization by xray		N					
77003	Fluoroguide for spine inject		N					

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77011	Ct scan for localization		N					
77012	Ct scan for needle biopsy		N					
77013	Ct guide for tissue ablation		N					
77014	Ct scan for therapy guide		N					
77021	Mr guidance for needle place		N					
77022	Mri for tissue ablation		N					
77031	Stereotact guide for brst bx		N					
77032	Guidance for needle breast		N					
77051	Computer dx mammogram add-on		A					
77052	Comp screen mammogram add-on		A					
77053	X-ray of mammary duct		Q2	0263	3.3387	$229.96	.	$46.00
77054	X-ray of mammary ducts		Q2	0263	3.3387	$229.96	.	$46.00
77055	Mammogram one breast		A					
77056	Mammogram both breasts		A					
77057	Mammogram screening		A					
77058	Mri one breast		B					
77059	Mri both breasts		B					
77071	X-ray stress view		X	0260	0.6539	$45.04	.	$9.01
77072	X-rays for bone age		X	0260	0.6539	$45.04	.	$9.01
77073	X-rays bone length studies		X	0260	0.6539	$45.04	.	$9.01
77074	X-rays bone survey limited		X	0261	1.1014	$75.86	.	$15.18
77075	X-rays bone survey complete		X	0261	1.1014	$75.86	.	$15.18
77076	X-rays bone survey infant		X	0261	1.1014	$75.86	.	$15.18
77077	Joint survey single view		X	0260	0.6539	$45.04	.	$9.01
77078	Ct bone density axial		S	0288	1.0238	$70.52	$0.00	$0.00
77079	Ct bone density peripheral		S	0282	1.6478	$113.49	$0.00	$0.00
77080	Dxa bone density axial		S	0288	1.0238	$70.52	$0.00	$0.00
77081	Dxa bone density/peripheral		S	0665	0.4662	$32.11	$0.00	$0.00
77082	Dxa bone density vert fx		X	0260	0.6539	$45.04	.	$9.01
77083	Radiographic absorptiometry		X	0261	1.1014	$75.86	$0.00	$0.00
77084	Magnetic image bone marrow		S	0336	4.9789	$342.93	$135.13	$68.59
77261	Radiation therapy planning		B					
77262	Radiation therapy planning		B					
77263	Radiation therapy planning		B					
77280	Set radiation therapy field		X	0304	1.5169	$104.48	$34.63	$20.90
77285	Set radiation therapy field		X	0305	3.9434	$271.61	$91.38	$54.33
77290	Set radiation therapy field		X	0305	3.9434	$271.61	$91.38	$54.33

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77295	Set radiation therapy field		X	0310	13.4552	$926.74	$325.27	$185.35
77299	Radiation therapy planning		X	0304	1.5169	$104.48	$34.63	$20.90
77300	Radiation therapy dose plan		X	0304	1.5169	$104.48	$34.63	$20.90
77301	Radiotherapy dose plan imrt		X	0310	13.4552	$926.74	$325.27	$185.35
77305	Teletx isodose plan simple		X	0304	1.5169	$104.48	$34.63	$20.90
77310	Teletx isodose plan intermed		X	0304	1.5169	$104.48	$34.63	$20.90
77315	Teletx isodose plan complex		X	0305	3.9434	$271.61	$91.38	$54.33
77321	Special teletx port plan		X	0305	3.9434	$271.61	$91.38	$54.33
77326	Brachytx isodose calc simp		X	0304	1.5169	$104.48	$34.63	$20.90
77327	Brachytx isodose calc interm		X	0305	3.9434	$271.61	$91.38	$54.33
77328	Brachytx isodose plan compl		X	0305	3.9434	$271.61	$91.38	$54.33
77331	Special radiation dosimetry		X	0304	1.5169	$104.48	$34.63	$20.90
77332	Radiation treatment aid(s)		X	0303	2.8996	$199.71	$66.95	$39.95
77333	Radiation treatment aid(s)		X	0303	2.8996	$199.71	$66.95	$39.95
77334	Radiation treatment aid(s)		X	0303	2.8996	$199.71	$66.95	$39.95
77336	Radiation physics consult		X	0304	1.5169	$104.48	$34.63	$20.90
77338	Design mlc device for imrt	CH	X	0310	13.4552	$926.74	$325.27	$185.35
77370	Radiation physics consult		X	0304	1.5169	$104.48	$34.63	$20.90
77371	Srs multisource		S	0127	111.2310	$7,661.15	.	$1,532.23
77372	Srs linear based		B					
77373	Sbrt delivery		B					
77399	External radiation dosimetry		X	0304	1.5169	$104.48	$34.63	$20.90
77401	Radiation treatment delivery		S	0300	1.4202	$97.82	.	$19.57
77402	Radiation treatment delivery		S	0300	1.4202	$97.82	.	$19.57
77403	Radiation treatment delivery		S	0300	1.4202	$97.82	.	$19.57
77404	Radiation treatment delivery		S	0300	1.4202	$97.82	.	$19.57
77406	Radiation treatment delivery	CH	S	0300	1.4202	$97.82	.	$19.57
77407	Radiation treatment delivery		S	0300	1.4202	$97.82	.	$19.57
77408	Radiation treatment delivery		S	0300	1.4202	$97.82	.	$19.57
77409	Radiation treatment delivery		S	0300	1.4202	$97.82	.	$19.57
77411	Radiation treatment delivery		S	0301	2.3309	$160.54	.	$32.11
77412	Radiation treatment delivery		S	0301	2.3309	$160.54	.	$32.11
77413	Radiation treatment delivery		S	0301	2.3309	$160.54	.	$32.11
77414	Radiation treatment delivery		S	0301	2.3309	$160.54	.	$32.11
77416	Radiation treatment delivery		S	0301	2.3309	$160.54	.	$32.11
77417	Radiology port film(s)		N					
77418	Radiation tx delivery imrt		S	0412	6.3625	$438.22		$87.65
77421	Stereoscopic x-ray guidance		N					
77422	Neutron beam tx simple		S	0301	2.3309	$160.54	.	$32.11

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77423	Neutron beam tx complex		S	0301	2.3309	$160.54	.	$32.11
77427	Radiation tx management x5		B					
77431	Radiation therapy management		B					
77432	Stereotactic radiation trmt		B					
77435	Sbrt management		N					
77470	Special radiation treatment		S	0299	5.6418	$388.58	.	$77.72
77499	Radiation therapy management		B					
77520	Proton trmt simple w/o comp		S	0664	14.9792	$1,031.71	.	$206.35
77522	Proton trmt simple w/comp		S	0664	14.9792	$1,031.71	.	$206.35
77523	Proton trmt intermediate		S	0667	19.5948	$1,349.61	.	$269.93
77525	Proton treatment complex		S	0667	19.5948	$1,349.61	.	$269.93
77600	Hyperthermia treatment		S	0299	5.6418	$388.58	.	$77.72
77605	Hyperthermia treatment		S	0299	5.6418	$388.58	.	$77.72
77610	Hyperthermia treatment		S	0299	5.6418	$388.58	.	$77.72
77615	Hyperthermia treatment		S	0299	5.6418	$388.58	.	$77.72
77620	Hyperthermia treatment		S	0299	5.6418	$388.58	.	$77.72
77750	Infuse radioactive materials		S	0301	2.3309	$160.54	.	$32.11
77761	Apply intrcav radiat simple		S	0312	5.1535	$354.95	.	$70.99
77762	Apply intrcav radiat interm		S	0312	5.1535	$354.95	.	$70.99
77763	Apply intrcav radiat compl		S	0312	5.1535	$354.95	.	$70.99
77776	Apply interstit radiat simpl		S	0312	5.1535	$354.95	.	$70.99
77777	Apply interstit radiat inter		S	0312	5.1535	$354.95	.	$70.99
77778	Apply interstit radiat compl		Q3	0651	16.3985	$1,129.46	.	$225.90
77785	Hdr brachytx 1 channel		S	0313	10.1646	$700.10	$264.73	$140.02
77786	Hdr brachytx 2-12 channel		S	0313	10.1646	$700.10	$264.73	$140.02
77787	Hdr brachytx over 12 chan		S	0313	10.1646	$700.10	$264.73	$140.02
77789	Apply surface radiation		S	0300	1.4202	$97.82	.	$19.57
77790	Radiation handling		N					
77799	Radium/radioisotope therapy		S	0312	5.1535	$354.95	.	$70.99
78000	Thyroid single uptake		S	0389	1.4630	$100.77	$26.88	$20.16
78001	Thyroid multiple uptakes		S	0389	1.4630	$100.77	$26.88	$20.16
78003	Thyroid suppress/stimul		S	0389	1.4630	$100.77	$26.88	$20.16
78006	Thyroid imaging with uptake		S	0391	3.1868	$219.49	$65.46	$43.90
78007	Thyroid image mult uptakes		S	0391	3.1868	$219.49	$65.46	$43.90
78010	Thyroid imaging		S	0390	1.9280	$132.79	$47.69	$26.56
78011	Thyroid imaging with flow		S	0390	1.9280	$132.79	$47.69	$26.56
78015	Thyroid met imaging		S	0406	4.2121	$290.11	$88.01	$58.03
78016	Thyroid met imaging/studies		S	0406	4.2121	$290.11	$88.01	$58.03
78018	Thyroid met imaging body		S	0406	4.2121	$290.11	$88.01	$58.03

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78020	Thyroid met uptake		N					
78070	Parathyroid nuclear imaging		S	0391	3.1868	$219.49	$65.46	$43.90
78075	Adrenal nuclear imaging		S	0408	11.9819	$825.27	.	$165.06
78099	Endocrine nuclear procedure		S	0390	1.9280	$132.79	$47.69	$26.56
78102	Bone marrow imaging ltd		S	0400	3.7316	$257.02	$91.24	$51.41
78103	Bone marrow imaging mult		S	0400	3.7316	$257.02	$91.24	$51.41
78104	Bone marrow imaging body		S	0400	3.7316	$257.02	$91.24	$51.41
78110	Plasma volume single		S	0393	6.0745	$418.39	.	$83.68
78111	Plasma volume multiple		S	0393	6.0745	$418.39	.	$83.68
78120	Red cell mass single		S	0393	6.0745	$418.39	.	$83.68
78121	Red cell mass multiple		S	0393	6.0745	$418.39	.	$83.68
78122	Blood volume		S	0393	6.0745	$418.39	.	$83.68
78130	Red cell survival study		S	0393	6.0745	$418.39	.	$83.68
78135	Red cell survival kinetics		S	0393	6.0745	$418.39	.	$83.68
78140	Red cell sequestration		S	0393	6.0745	$418.39	.	$83.68
78185	Spleen imaging		S	0400	3.7316	$257.02	$91.24	$51.41
78190	Platelet survival kinetics		S	0392	2.5248	$173.90	$42.39	$34.78
78191	Platelet survival		S	0392	2.5248	$173.90	$42.39	$34.78
78195	Lymph system imaging		S	0400	3.7316	$257.02	$91.24	$51.41
78199	Blood/lymph nuclear exam		S	0400	3.7316	$257.02	$91.24	$51.41
78201	Liver imaging		S	0394	3.8494	$265.13	$90.78	$53.03
78202	Liver imaging with flow		S	0394	3.8494	$265.13	$90.78	$53.03
78205	Liver imaging (3D)		S	0394	3.8494	$265.13	$90.78	$53.03
78206	Liver image (3d) with flow		S	0394	3.8494	$265.13	$90.78	$53.03
78215	Liver and spleen imaging		S	0394	3.8494	$265.13	$90.78	$53.03
78216	Liver & spleen image/flow		S	0394	3.8494	$265.13	$90.78	$53.03
78220	Liver function study		S	0394	3.8494	$265.13	$90.78	$53.03
78223	Hepatobiliary imaging		S	0394	3.8494	$265.13	$90.78	$53.03
78230	Salivary gland imaging		S	0395	3.4743	$239.30	$87.01	$47.86
78231	Serial salivary imaging		S	0395	3.4743	$239.30	$87.01	$47.86
78232	Salivary gland function exam		S	0395	3.4743	$239.30	$87.01	$47.86
78258	Esophageal motility study		S	0395	3.4743	$239.30	$87.01	$47.86
78261	Gastric mucosa imaging		S	0395	3.4743	$239.30	$87.01	$47.86
78262	Gastroesophageal reflux exam		S	0395	3.4743	$239.30	$87.01	$47.86
78264	Gastric emptying study		S	0395	3.4743	$239.30	$87.01	$47.86
78267	Breath tst attain/anal c-14		A					
78268	Breath test analysis c-14		A					
78270	Vit B-12 absorption exam		S	0392	2.5248	$173.90	$42.39	$34.78
78271	Vit b-12 absrp exam int fac		S	0392	2.5248	$173.90	$42.39	$34.78

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78272	Vit b-12 absorp combined		S	0392	2.5248	$173.90	$42.39	$34.78
78278	Acute GI blood loss imaging		S	0395	3.4743	$239.30	$87.01	$47.86
78282	GI protein loss exam		S	0395	3.4743	$239.30	$87.01	$47.86
78290	Meckels divert exam		S	0395	3.4743	$239.30	$87.01	$47.86
78291	Leveen/shunt patency exam		S	0395	3.4743	$239.30	$87.01	$47.86
78299	GI nuclear procedure		S	0395	3.4743	$239.30	$87.01	$47.86
78300	Bone imaging limited area		S	0396	3.5527	$244.70	$94.20	$48.94
78305	Bone imaging multiple areas		S	0396	3.5527	$244.70	$94.20	$48.94
78306	Bone imaging whole body		S	0396	3.5527	$244.70	$94.20	$48.94
78315	Bone imaging 3 phase		S	0396	3.5527	$244.70	$94.20	$48.94
78320	Bone imaging (3D)		S	0396	3.5527	$244.70	$94.20	$48.94
78350	Bone mineral single photon		E					
78351	Bone mineral dual photon		E					
78399	Musculoskeletal nuclear exam		S	0396	3.5527	$244.70	$94.20	$48.94
78414	Non-imaging heart function		S	0398	4.2306	$291.39	$93.33	$58.28
78428	Cardiac shunt imaging		S	0398	4.2306	$291.39	$93.33	$58.28
78445	Vascular flow imaging		S	0397	2.9089	$200.35	$46.29	$40.07
78451	Ht muscle image spect sing		S	0377	11.0328	$759.90	.	$151.98
78452	Ht muscle image spect mult		S	0377	11.0328	$759.90	.	$151.98
78453	Ht muscle image planar sing		S	0377	11.0328	$759.90	.	$151.98
78454	Ht musc image planar mult		S	0377	11.0328	$759.90	.	$151.98
78456	Acute venous thrombus image		S	0397	2.9089	$200.35	$46.29	$40.07
78457	Venous thrombosis imaging		S	0397	2.9089	$200.35	$46.29	$40.07
78458	Ven thrombosis images bilat		S	0397	2.9089	$200.35	$46.29	$40.07
78459	Heart muscle imaging (PET)		S	0307	16.0776	$1,107.36	.	$221.48
78466	Heart infarct image		S	0398	4.2306	$291.39	$93.33	$58.28
78468	Heart infarct image (ef)		S	0398	4.2306	$291.39	$93.33	$58.28
78469	Heart infarct image (3D)		S	0398	4.2306	$291.39	$93.33	$58.28
78472	Gated heart planar single		S	0398	4.2306	$291.39	$93.33	$58.28
78473	Gated heart multiple		S	0398	4.2306	$291.39	$93.33	$58.28
78481	Heart first pass single		S	0398	4.2306	$291.39	$93.33	$58.28
78483	Heart first pass multiple		S	0398	4.2306	$291.39	$93.33	$58.28
78491	Heart image (pet) single		S	0307	16.0776	$1,107.36	.	$221.48
78492	Heart image (pet) multiple		S	0307	16.0776	$1,107.36	.	$221.48
78494	Heart image spect		S	0398	4.2306	$291.39	$93.33	$58.28
78496	Heart first pass add-on		N					
78499	Cardiovascular nuclear exam		S	0398	4.2306	$291.39	$93.33	$58.28
78580	Lung perfusion imaging		S	0401	2.8578	$196.83	$71.16	$39.37
78584	Lung V/Q image single breath		S	0378	4.6449	$319.92	$123.46	$63.99

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78585	Lung V/Q imaging		S	0378	4.6449	$319.92	$123.46	$63.99
78586	Aerosol lung image single		S	0401	2.8578	$196.83	$71.16	$39.37
78587	Aerosol lung image multiple		S	0401	2.8578	$196.83	$71.16	$39.37
78588	Perfusion lung image		S	0378	4.6449	$319.92	$123.46	$63.99
78591	Vent image 1 breath 1 proj		S	0401	2.8578	$196.83	$71.16	$39.37
78593	Vent image 1 proj gas		S	0401	2.8578	$196.83	$71.16	$39.37
78594	Vent image mult proj gas		S	0401	2.8578	$196.83	$71.16	$39.37
78596	Lung differential function		S	0378	4.6449	$319.92	$123.46	$63.99
78599	Respiratory nuclear exam		S	0401	2.8578	$196.83	$71.16	$39.37
78600	Brain image < 4 views		S	0403	3.4879	$240.23	$72.42	$48.05
78601	Brain image w/flow < 4 views		S	0402	8.6571	$596.27	.	$119.26
78605	Brain image 4+ views		S	0403	3.4879	$240.23	$72.42	$48.05
78606	Brain image w/flow 4 + views		S	0402	8.6571	$596.27	.	$119.26
78607	Brain imaging (3D)		S	0402	8.6571	$596.27	.	$119.26
78608	Brain imaging (PET)		S	0308	15.1285	$1,041.99	.	$208.40
78609	Brain imaging (PET)		E					
78610	Brain flow imaging only		S	0403	3.4879	$240.23	$72.42	$48.05
78630	Cerebrospinal fluid scan		S	0402	8.6571	$596.27	.	$119.26
78635	CSF ventriculography		S	0402	8.6571	$596.27	.	$119.26
78645	CSF shunt evaluation		S	0403	3.4879	$240.23	$72.42	$48.05
78647	Cerebrospinal fluid scan		S	0402	8.6571	$596.27	.	$119.26
78650	CSF leakage imaging		S	0402	8.6571	$596.27	.	$119.26
78660	Nuclear exam of tear flow		S	0403	3.4879	$240.23	$72.42	$48.05
78699	Nervous system nuclear exam		S	0403	3.4879	$240.23	$72.42	$48.05
78700	Kidney imaging morphol		S	0404	4.6672	$321.46	$82.19	$64.30
78701	Kidney imaging with flow		S	0404	4.6672	$321.46	$82.19	$64.30
78707	K flow/funct image w/o drug		S	0404	4.6672	$321.46	$82.19	$64.30
78708	K flow/funct image w/drug		S	0404	4.6672	$321.46	$82.19	$64.30
78709	K flow/funct image multiple		S	0404	4.6672	$321.46	$82.19	$64.30
78710	Kidney imaging (3D)		S	0404	4.6672	$321.46	$82.19	$64.30
78725	Kidney function study		S	0392	2.5248	$173.90	$42.39	$34.78
78730	Urinary bladder retention		S	0389	1.4630	$100.77	$26.88	$20.16
78740	Ureteral reflux study		S	0404	4.6672	$321.46	$82.19	$64.30
78761	Testicular imaging w/flow		S	0404	4.6672	$321.46	$82.19	$64.30
78799	Genitourinary nuclear exam		S	0404	4.6672	$321.46	$82.19	$64.30
78800	Tumor imaging limited area		S	0406	4.2121	$290.11	$88.01	$58.03
78801	Tumor imaging mult areas		S	0414	6.8961	$474.98	.	$95.00
78802	Tumor imaging whole body		S	0414	6.8961	$474.98	.	$95.00
78803	Tumor imaging (3D)		S	0414	6.8961	$474.98	.	$95.00

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78804	Tumor imaging whole body		S	0408	11.9819	$825.27	.	$165.06
78805	Abscess imaging ltd area		S	0414	6.8961	$474.98	.	$95.00
78806	Abscess imaging whole body		S	0414	6.8961	$474.98	.	$95.00
78807	Nuclear localization/abscess	CH	S	0414	6.8961	$474.98	.	$95.00
78808	Iv inj ra drug dx study		Q1	0392	2.5248	$173.90	$42.39	$34.78
78811	Pet image ltd area		S	0308	15.1285	$1,041.99	.	$208.40
78812	Pet image skull-thigh		S	0308	15.1285	$1,041.99	.	$208.40
78813	Pet image full body		S	0308	15.1285	$1,041.99	.	$208.40
78814	Pet image w/ct lmtd		S	0308	15.1285	$1,041.99	.	$208.40
78815	Pet image w/ct skull-thigh		S	0308	15.1285	$1,041.99	.	$208.40
78816	Pet image w/ct full body		S	0308	15.1285	$1,041.99	.	$208.40
78999	Nuclear diagnostic exam		S	0389	1.4630	$100.77	$26.88	$20.16
79005	Nuclear rx oral admin		S	0407	3.2539	$224.12	$78.13	$44.83
79101	Nuclear rx iv admin		S	0407	3.2539	$224.12	$78.13	$44.83
79200	Nuclear rx intracav admin		S	0413	4.7474	$326.98	.	$65.40
79300	Nuclr rx interstit colloid		S	0407	3.2539	$224.12	$78.13	$44.83
79403	Hematopoietic nuclear tx		S	0413	4.7474	$326.98	.	$65.40
79440	Nuclear rx intra-articular		S	0413	4.7474	$326.98	.	$65.40
79445	Nuclear rx intra-arterial		S	0407	3.2539	$224.12	$78.13	$44.83
79999	Nuclear medicine therapy		S	0407	3.2539	$224.12	$78.13	$44.83
80047	Metabolic panel ionized ca		A					
80048	Metabolic panel total ca		A					
80050	General health panel		E					
80051	Electrolyte panel		A					
80053	Comprehen metabolic panel		A					
80055	Obstetric panel		E					
80061	Lipid panel		A					
80069	Renal function panel		A					
80074	Acute hepatitis panel		A					
80076	Hepatic function panel		A					
80100	Drug screen qualitate/multi		A					
80101	Drug screen single		E					
80102	Drug confirmation		A					
80103	Drug analysis tissue prep		N					
80104	Drug scrn 1+ class nonchromo	NI	E					
80150	Assay of amikacin		A					
80152	Assay of amitriptyline		A					
80154	Assay of benzodiazepines		A					
80156	Assay carbamazepine total		A					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80157	Assay carbamazepine free		A					
80158	Assay of cyclosporine		A					
80160	Assay of desipramine		A					
80162	Assay of digoxin		A					
80164	Assay dipropylacetic acid		A					
80166	Assay of doxepin		A					
80168	Assay of ethosuximide		A					
80170	Assay of gentamicin		A					
80172	Assay of gold		A					
80173	Assay of haloperidol		A					
80174	Assay of imipramine		A					
80176	Assay of lidocaine		A					
80178	Assay of lithium		A					
80182	Assay of nortriptyline		A					
80184	Assay of phenobarbital		A					
80185	Assay of phenytoin total		A					
80186	Assay of phenytoin free		A					
80188	Assay of primidone		A					
80190	Assay of procainamide		A					
80192	Assay of procainamide		A					
80194	Assay of quinidine		A					
80195	Assay of sirolimus		A					
80196	Assay of salicylate		A					
80197	Assay of tacrolimus		A					
80198	Assay of theophylline		A					
80200	Assay of tobramycin		A					
80201	Assay of topiramate		A					
80202	Assay of vancomycin		A					
80299	Quantitative assay drug		A					
80400	Acth stimulation panel		A					
80402	Acth stimulation panel		A					
80406	Acth stimulation panel		A					
80408	Aldosterone suppression eval		A					
80410	Calcitonin stimul panel		A					
80412	CRH stimulation panel		A					
80414	Testosterone response		A					
80415	Estradiol response panel		A					
80416	Renin stimulation panel		A					
80417	Renin stimulation panel		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80418	Pituitary evaluation panel		A					
80420	Dexamethasone panel		A					
80422	Glucagon tolerance panel		A					
80424	Glucagon tolerance panel		A					
80426	Gonadotropin hormone panel		A					
80428	Growth hormone panel		A					
80430	Growth hormone panel		A					
80432	Insulin suppression panel		A					
80434	Insulin tolerance panel		A					
80435	Insulin tolerance panel		A					
80436	Metyrapone panel		A					
80438	TRH stimulation panel		A					
80439	TRH stimulation panel		A					
80440	TRH stimulation panel		A					
80500	Lab pathology consultation		X	0433	0.2478	$17.07	$5.17	$3.42
80502	Lab pathology consultation		X	0342	0.1603	$11.04	.	$2.21
81000	Urinalysis nonauto w/scope		A					
81001	Urinalysis auto w/scope		A					
81002	Urinalysis nonauto w/o scope		A					
81003	Urinalysis auto w/o scope		A					
81005	Urinalysis		A					
81007	Urine screen for bacteria		A					
81015	Microscopic exam of urine		A					
81020	Urinalysis glass test		A					
81025	Urine pregnancy test		A					
81050	Urinalysis volume measure		A					
81099	Urinalysis test procedure		A					
82000	Assay of blood acetaldehyde		A					
82003	Assay of acetaminophen		A					
82009	Test for acetone/ketones		A					
82010	Acetone assay		A					
82013	Acetylcholinesterase assay		A					
82016	Acylcarnitines qual		A					
82017	Acylcarnitines quant		A					
82024	Assay of acth		A					
82030	Assay of adp & amp		A					
82040	Assay of serum albumin		A					
82042	Assay of urine albumin		A					
82043	Microalbumin quantitative		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82044	Microalbumin semiquant		A					
82045	Albumin ischemia modified		A					
82055	Assay of ethanol		A					
82075	Assay of breath ethanol		A					
82085	Assay of aldolase		A					
82088	Assay of aldosterone		A					
82101	Assay of urine alkaloids		A					
82103	Alpha-1-antitrypsin total		A					
82104	Alpha-1-antitrypsin pheno		A					
82105	Alpha-fetoprotein serum		A					
82106	Alpha-fetoprotein amniotic		A					
82107	Alpha-fetoprotein l3		A					
82108	Assay of aluminum		A					
82120	Amines vaginal fluid qual		A					
82127	Amino acid single qual		A					
82128	Amino acids mult qual		A					
82131	Amino acids single quant		A					
82135	Assay aminolevulinic acid		A					
82136	Amino acids quant 2-5		A					
82139	Amino acids quan 6 or more		A					
82140	Assay of ammonia		A					
82143	Amniotic fluid scan		A					
82145	Assay of amphetamines		A					
82150	Assay of amylase		A					
82154	Androstanediol glucuronide		A					
82157	Assay of androstenedione		A					
82160	Assay of androsterone		A					
82163	Assay of angiotensin II		A					
82164	Angiotensin I enzyme test		A					
82172	Assay of apolipoprotein		A					
82175	Assay of arsenic		A					
82180	Assay of ascorbic acid		A					
82190	Atomic absorption		A					
82205	Assay of barbiturates		A					
82232	Assay of beta-2 protein		A					
82239	Bile acids total		A					
82240	Bile acids cholylglycine		A					
82247	Bilirubin total		A					
82248	Bilirubin direct		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82252	Fecal bilirubin test		A					
82261	Assay of biotinidase		A					
82270	Occult blood feces		A					
82271	Occult blood other sources		A					
82272	Occult bld feces 1-3 tests		A					
82274	Assay test for blood fecal		A					
82286	Assay of bradykinin		A					
82300	Assay of cadmium		A					
82306	Vitamin d 25 hydroxy		A					
82308	Assay of calcitonin		A					
82310	Assay of calcium		A					
82330	Assay of calcium		A					
82331	Calcium infusion test		A					
82340	Assay of calcium in urine		A					
82355	Calculus analysis qual		A					
82360	Calculus assay quant		A					
82365	Calculus spectroscopy		A					
82370	X-ray assay calculus		A					
82373	Assay c-d transfer measure		A					
82374	Assay blood carbon dioxide		A					
82375	Assay carboxyhb quant		A					
82376	Assay carboxyhb qual		A					
82378	Carcinoembryonic antigen		A					
82379	Assay of carnitine		A					
82380	Assay of carotene		A					
82382	Assay urine catecholamines		A					
82383	Assay blood catecholamines		A					
82384	Assay three catecholamines		A					
82387	Assay of cathepsin-d		A					
82390	Assay of ceruloplasmin		A					
82397	Chemiluminescent assay		A					
82415	Assay of chloramphenicol		A					
82435	Assay of blood chloride		A					
82436	Assay of urine chloride		A					
82438	Assay other fluid chlorides		A					
82441	Test for chlorohydrocarbons		A					
82465	Assay bld/serum cholesterol		A					
82480	Assay serum cholinesterase		A					
82482	Assay rbc cholinesterase		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82485	Assay chondroitin sulfate		A					
82486	Gas/liquid chromatography		A					
82487	Paper chromatography		A					
82488	Paper chromatography		A					
82489	Thin layer chromatography		A					
82491	Chromotography quant sing		A					
82492	Chromotography quant mult		A					
82495	Assay of chromium		A					
82507	Assay of citrate		A					
82520	Assay of cocaine		A					
82523	Collagen crosslinks		A					
82525	Assay of copper		A					
82528	Assay of corticosterone		A					
82530	Cortisol free		A					
82533	Total cortisol		A					
82540	Assay of creatine		A					
82541	Column chromotography qual		A					
82542	Column chromotography quant		A					
82543	Column chromotograph/isotope		A					
82544	Column chromotograph/isotope		A					
82550	Assay of ck (cpk)		A					
82552	Assay of cpk in blood		A					
82553	Creatine mb fraction		A					
82554	Creatine isoforms		A					
82565	Assay of creatinine		A					
82570	Assay of urine creatinine		A					
82575	Creatinine clearance test		A					
82585	Assay of cryofibrinogen		A					
82595	Assay of cryoglobulin		A					
82600	Assay of cyanide		A					
82607	Vitamin B-12		A					
82608	B-12 binding capacity		A					
82610	Cystatin c		A					
82615	Test for urine cystines		A					
82626	Dehydroepiandrosterone		A					
82627	Dehydroepiandrosterone		A					
82633	Desoxycorticosterone		A					
82634	Deoxycortisol		A					
82638	Assay of dibucaine number		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82646	Assay of dihydrocodeinone		A					
82649	Assay of dihydromorphinone		A					
82651	Assay of dihydrotestosterone		A					
82652	Vit d 1 25-dihydroxy		A					
82654	Assay of dimethadione		A					
82656	Pancreatic elastase fecal		A					
82657	Enzyme cell activity		A					
82658	Enzyme cell activity ra		A					
82664	Electrophoretic test		A					
82666	Assay of epiandrosterone		A					
82668	Assay of erythropoietin		A					
82670	Assay of estradiol		A					
82671	Assay of estrogens		A					
82672	Assay of estrogen		A					
82677	Assay of estriol		A					
82679	Assay of estrone		A					
82690	Assay of ethchlorvynol		A					
82693	Assay of ethylene glycol		A					
82696	Assay of etiocholanolone		A					
82705	Fats/lipids feces qual		A					
82710	Fats/lipids feces quant		A					
82715	Assay of fecal fat		A					
82725	Assay of blood fatty acids		A					
82726	Long chain fatty acids		A					
82728	Assay of ferritin		A					
82731	Assay of fetal fibronectin		A					
82735	Assay of fluoride		A					
82742	Assay of flurazepam		A					
82746	Blood folic acid serum		A					
82747	Assay of folic acid rbc		A					
82757	Assay of semen fructose		A					
82759	Assay of rbc galactokinase		A					
82760	Assay of galactose		A					
82775	Assay galactose transferase		A					
82776	Galactose transferase test		A					
82784	Assay iga/igd/igg/igm each		A					
82785	Assay of ige		A					
82787	Igg 1 2 3 or 4 each		A					
82800	Blood pH		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82803	Blood gases any combination		A					
82805	Blood gases w/o2 saturation		A					
82810	Blood gases o2 sat only		A					
82820	Hemoglobin-oxygen affinity		A					
82926	Assay of gastric acid	CH	D					
82928	Assay of gastric acid	CH	D					
82930	Gastric analy w/ph ea spec	NI	A					
82938	Gastrin test		A					
82941	Assay of gastrin		A					
82943	Assay of glucagon		A					
82945	Glucose other fluid		A					
82946	Glucagon tolerance test		A					
82947	Assay glucose blood quant		A					
82948	Reagent strip/blood glucose		A					
82950	Glucose test		A					
82951	Glucose tolerance test (GTT)		A					
82952	GTT-added samples		A					
82953	Glucose-tolbutamide test		A					
82955	Assay of g6pd enzyme		A					
82960	Test for G6PD enzyme		A					
82962	Glucose blood test		A					
82963	Assay of glucosidase		A					
82965	Assay of gdh enzyme		A					
82975	Assay of glutamine		A					
82977	Assay of GGT		A					
82978	Assay of glutathione		A					
82979	Assay rbc glutathione		A					
82980	Assay of glutethimide		A					
82985	Glycated protein		A					
83001	Gonadotropin (FSH)		A					
83002	Gonadotropin (LH)		A					
83003	Assay growth hormone (hgh)		A					
83008	Assay of guanosine		A					
83009	H pylori (c-13) blood		A					
83010	Assay of haptoglobin quant		A					
83012	Assay of haptoglobins		A					
83013	H pylori (c-13) breath		A					
83014	H pylori drug admin		A					
83015	Heavy metal screen		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83018	Quantitative screen metals		A					
83020	Hemoglobin electrophoresis		A					
83021	Hemoglobin chromotography		A					
83026	Hemoglobin copper sulfate		A					
83030	Fetal hemoglobin chemical		A					
83033	Fetal hemoglobin assay qual		A					
83036	Glycosylated hemoglobin test		A					
83037	Glycosylated hb home device		A					
83045	Blood methemoglobin test		A					
83050	Blood methemoglobin assay		A					
83051	Assay of plasma hemoglobin		A					
83055	Blood sulfhemoglobin test		A					
83060	Blood sulfhemoglobin assay		A					
83065	Assay of hemoglobin heat		A					
83068	Hemoglobin stability screen		A					
83069	Assay of urine hemoglobin		A					
83070	Assay of hemosiderin qual		A					
83071	Assay of hemosiderin quant		A					
83080	Assay of b hexosaminidase		A					
83088	Assay of histamine		A					
83090	Assay of homocystine		A					
83150	Assay of for hva		A					
83491	Assay of corticosteroids		A					
83497	Assay of 5-hiaa		A					
83498	Assay of progesterone		A					
83499	Assay of progesterone		A					
83500	Assay free hydroxyproline		A					
83505	Assay total hydroxyproline		A					
83516	Immunoassay nonantibody		A					
83518	Immunoassay dipstick		A					
83519	Ria nonantibody		A					
83520	Immunoassay quant nos nonab		A					
83525	Assay of insulin		A					
83527	Assay of insulin		A					
83528	Assay of intrinsic factor		A					
83540	Assay of iron		A					
83550	Iron binding test		A					
83570	Assay of idh enzyme		A					
83582	Assay of ketogenic steroids		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83586	Assay 17- ketosteroids		A					
83593	Fractionation ketosteroids		A					
83605	Assay of lactic acid		A					
83615	Lactate (LD) (LDH) enzyme		A					
83625	Assay of ldh enzymes		A					
83630	Lactoferrin fecal (qual)		A					
83631	Lactoferrin fecal (quant)		A					
83632	Placental lactogen		A					
83633	Test urine for lactose		A					
83634	Assay of urine for lactose		A					
83655	Assay of lead		A					
83661	L/s ratio fetal lung		A					
83662	Foam stability fetal lung		A					
83663	Fluoro polarize fetal lung		A					
83664	Lamellar bdy fetal lung		A					
83670	Assay of lap enzyme		A					
83690	Assay of lipase		A					
83695	Assay of lipoprotein(a)		A					
83698	Assay lipoprotein pla2		A					
83700	Lipopro bld electrophoretic		A					
83701	Lipoprotein bld hr fraction		A					
83704	Lipoprotein bld by nmr		A					
83718	Assay of lipoprotein		A					
83719	Assay of blood lipoprotein		A					
83721	Assay of blood lipoprotein		A					
83727	Assay of lrh hormone		A					
83735	Assay of magnesium		A					
83775	Assay of md enzyme		A					
83785	Assay of manganese		A					
83788	Mass spectrometry qual		A					
83789	Mass spectrometry quant		A					
83805	Assay of meprobamate		A					
83825	Assay of mercury		A					
83835	Assay of metanephrines		A					
83840	Assay of methadone		A					
83857	Assay of methemalbumin		A					
83858	Assay of methsuximide		A					
83861	Microfluid analy tears	NI	A					
83864	Mucopolysaccharides		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83866	Mucopolysaccharides screen		A					
83872	Assay synovial fluid mucin		A					
83873	Assay of csf protein		A					
83874	Assay of myoglobin		A					
83876	Assay myeloperoxidase		A					
83880	Natriuretic peptide		A					
83883	Assay nephelometry not spec		A					
83885	Assay of nickel		A					
83887	Assay of nicotine		A					
83890	Molecule isolate		A					
83891	Molecule isolate nucleic		A					
83892	Molecular diagnostics		A					
83893	Molecule dot/slot/blot		A					
83894	Molecule gel electrophor		A					
83896	Molecular diagnostics		A					
83897	Molecule nucleic transfer		A					
83898	Molecule nucleic ampli each		A					
83900	Molecule nucleic ampli 2 seq		A					
83901	Molecule nucleic ampli addon		A					
83902	Molecular diagnostics		A					
83903	Molecule mutation scan		A					
83904	Molecule mutation identify		A					
83905	Molecule mutation identify		A					
83906	Molecule mutation identify		A					
83907	Lyse cells for nucleic ext		A					
83908	Nucleic acid signal ampli		A					
83909	Nucleic acid high resolute		A					
83912	Genetic examination		A					
83913	Molecular rna stabilization		A					
83914	Mutation ident ola/sbce/aspe		A					
83915	Assay of nucleotidase		A					
83916	Oligoclonal bands		A					
83918	Organic acids total quant		A					
83919	Organic acids qual each		A					
83921	Organic acid single quant		A					
83925	Assay of opiates		A					
83930	Assay of blood osmolality		A					
83935	Assay of urine osmolality		A					
83937	Assay of osteocalcin		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83945	Assay of oxalate		A					
83950	Oncoprotein her-2/neu		A					
83951	Oncoprotein dcp		A					
83970	Assay of parathormone		A					
83986	Assay ph body fluid nos		A					
83987	Exhaled breath condensate		A					
83992	Assay for phencyclidine		A					
83993	Assay for calprotectin fecal		A					
84022	Assay of phenothiazine		A					
84030	Assay of blood pku		A					
84035	Assay of phenylketones		A					
84060	Assay acid phosphatase		A					
84061	Phosphatase forensic exam		A					
84066	Assay prostate phosphatase		A					
84075	Assay alkaline phosphatase		A					
84078	Assay alkaline phosphatase		A					
84080	Assay alkaline phosphatases		A					
84081	Amniotic fluid enzyme test		A					
84085	Assay of rbc pg6d enzyme		A					
84087	Assay phosphohexose enzymes		A					
84100	Assay of phosphorus		A					
84105	Assay of urine phosphorus		A					
84106	Test for porphobilinogen		A					
84110	Assay of porphobilinogen		A					
84112	Placenta alpha micro ig c/v	NI	A					
84119	Test urine for porphyrins		A					
84120	Assay of urine porphyrins		A					
84126	Assay of feces porphyrins		A					
84127	Assay of feces porphyrins		A					
84132	Assay of serum potassium		A					
84133	Assay of urine potassium		A					
84134	Assay of prealbumin		A					
84135	Assay of pregnanediol		A					
84138	Assay of pregnanetriol		A					
84140	Assay of pregnenolone		A					
84143	Assay of 17-hydroxypregneno		A					
84144	Assay of progesterone		A					
84145	Procalcitonin (pct)		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84146	Assay of prolactin		A					
84150	Assay of prostaglandin		A					
84152	Assay of psa complexed		A					
84153	Assay of psa total		A					
84154	Assay of psa free		A					
84155	Assay of protein serum		A					
84156	Assay of protein urine		A					
84157	Assay of protein other		A					
84160	Assay of protein any source		A					
84163	Pappa serum		A					
84165	Protein e-phoresis serum		A					
84166	Protein e-phoresis/urine/csf		A					
84181	Western blot test		A					
84182	Protein western blot test		A					
84202	Assay RBC protoporphyrin		A					
84203	Test RBC protoporphyrin		A					
84206	Assay of proinsulin		A					
84207	Assay of vitamin b-6		A					
84210	Assay of pyruvate		A					
84220	Assay of pyruvate kinase		A					
84228	Assay of quinine		A					
84233	Assay of estrogen		A					
84234	Assay of progesterone		A					
84235	Assay of endocrine hormone		A					
84238	Assay nonendocrine receptor		A					
84244	Assay of renin		A					
84252	Assay of vitamin b-2		A					
84255	Assay of selenium		A					
84260	Assay of serotonin		A					
84270	Assay of sex hormone globul		A					
84275	Assay of sialic acid		A					
84285	Assay of silica		A					
84295	Assay of serum sodium		A					
84300	Assay of urine sodium		A					
84302	Assay of sweat sodium		A					
84305	Assay of somatomedin		A					
84307	Assay of somatostatin		A					
84311	Spectrophotometry		A					
84315	Body fluid specific gravity		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84375	Chromatogram assay sugars		A					
84376	Sugars single qual		A					
84377	Sugars multiple qual		A					
84378	Sugars single quant		A					
84379	Sugars multiple quant		A					
84392	Assay of urine sulfate		A					
84402	Assay of testosterone		A					
84403	Assay of total testosterone		A					
84425	Assay of vitamin b-1		A					
84430	Assay of thiocyanate		A					
84431	Thromboxane urine		A					
84432	Assay of thyroglobulin		A					
84436	Assay of total thyroxine		A					
84437	Assay of neonatal thyroxine		A					
84439	Assay of free thyroxine		A					
84442	Assay of thyroid activity		A					
84443	Assay thyroid stim hormone		A					
84445	Assay of tsi		A					
84446	Assay of vitamin e		A					
84449	Assay of transcortin		A					
84450	Transferase (AST) (SGOT)		A					
84460	Alanine amino (ALT) (SGPT)		A					
84466	Assay of transferrin		A					
84478	Assay of triglycerides		A					
84479	Assay of thyroid (t3 or t4)		A					
84480	Assay triiodothyronine (t3)		A					
84481	Free assay (FT-3)		A					
84482	T3 reverse		A					
84484	Assay of troponin quant		A					
84485	Assay duodenal fluid trypsin		A					
84488	Test feces for trypsin		A					
84490	Assay of feces for trypsin		A					
84510	Assay of tyrosine		A					
84512	Assay of troponin qual		A					
84520	Assay of urea nitrogen		A					
84525	Urea nitrogen semi-quant		A					
84540	Assay of urine/urea-n		A					
84545	Urea-N clearance test		A					
84550	Assay of blood/uric acid		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84560	Assay of urine/uric acid		A					
84577	Assay of feces/urobilinogen		A					
84578	Test urine urobilinogen		A					
84580	Assay of urine urobilinogen		A					
84583	Assay of urine urobilinogen		A					
84585	Assay of urine vma		A					
84586	Assay of vip		A					
84588	Assay of vasopressin		A					
84590	Assay of vitamin a		A					
84591	Assay of nos vitamin		A					
84597	Assay of vitamin k		A					
84600	Assay of volatiles		A					
84620	Xylose tolerance test		A					
84630	Assay of zinc		A					
84681	Assay of c-peptide		A					
84702	Chorionic gonadotropin test		A					
84703	Chorionic gonadotropin assay		A					
84704	Hcg free betachain test		A					
84830	Ovulation tests		A					
84999	Clinical chemistry test		A					
85002	Bleeding time test		A					
85004	Automated diff wbc count		A					
85007	Bl smear w/diff wbc count		A					
85008	Bl smear w/o diff wbc count		A					
85009	Manual diff wbc count b-coat		A					
85013	Spun microhematocrit		A					
85014	Hematocrit		A					
85018	Hemoglobin		A					
85025	Complete cbc w/auto diff wbc		A					
85027	Complete cbc automated		A					
85032	Manual cell count each		A					
85041	Automated rbc count		A					
85044	Manual reticulocyte count		A					
85045	Automated reticulocyte count		A					
85046	Reticyte/hgb concentrate		A					
85048	Automated leukocyte count		A					
85049	Automated platelet count		A					
85055	Reticulated platelet assay		A					
85060	Blood smear interpretation		B					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85097	Bone marrow interpretation		X	0343	0.5296	$36.48	$10.84	$7.30
85130	Chromogenic substrate assay		A					
85170	Blood clot retraction		A					
85175	Blood clot lysis time		A					
85210	Blood clot factor II test		A					
85220	Blood clot factor V test		A					
85230	Blood clot factor VII test		A					
85240	Blood clot factor VIII test		A					
85244	Blood clot factor VIII test		A					
85245	Blood clot factor VIII test		A					
85246	Blood clot factor VIII test		A					
85247	Blood clot factor VIII test		A					
85250	Blood clot factor IX test		A					
85260	Blood clot factor X test		A					
85270	Blood clot factor XI test		A					
85280	Blood clot factor XII test		A					
85290	Blood clot factor XIII test		A					
85291	Blood clot factor XIII test		A					
85292	Blood clot factor assay		A					
85293	Blood clot factor assay		A					
85300	Antithrombin III test		A					
85301	Antithrombin III test		A					
85302	Blood clot inhibitor antigen		A					
85303	Blood clot inhibitor test		A					
85305	Blood clot inhibitor assay		A					
85306	Blood clot inhibitor test		A					
85307	Assay activated protein c		A					
85335	Factor inhibitor test		A					
85337	Thrombomodulin		A					
85345	Coagulation time		A					
85347	Coagulation time		A					
85348	Coagulation time		A					
85360	Euglobulin lysis		A					
85362	Fibrin degradation products		A					
85366	Fibrinogen test		A					
85370	Fibrinogen test		A					
85378	Fibrin degrade semiquant		A					
85379	Fibrin degradation quant		A					
85380	Fibrin degradation vte		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85384	Fibrinogen		A					
85385	Fibrinogen		A					
85390	Fibrinolysins screen		A					
85396	Clotting assay whole blood		N					
85397	Clotting funct activity		A					
85400	Fibrinolytic plasmin		A					
85410	Fibrinolytic antiplasmin		A					
85415	Fibrinolytic plasminogen		A					
85420	Fibrinolytic plasminogen		A					
85421	Fibrinolytic plasminogen		A					
85441	Heinz bodies direct		A					
85445	Heinz bodies induced		A					
85460	Hemoglobin fetal		A					
85461	Hemoglobin fetal		A					
85475	Hemolysin		A					
85520	Heparin assay		A					
85525	Heparin neutralization		A					
85530	Heparin-protamine tolerance		A					
85536	Iron stain peripheral blood		A					
85540	Wbc alkaline phosphatase		A					
85547	RBC mechanical fragility		A					
85549	Muramidase		A					
85555	RBC osmotic fragility		A					
85557	RBC osmotic fragility		A					
85576	Blood platelet aggregation		A					
85597	Phospholipid pltlt neutraliz		A					
85598	Hexagnal phosph pltlt neutrl	NI	A					
85610	Prothrombin time		A					
85611	Prothrombin test		A					
85612	Viper venom prothrombin time		A					
85613	Russell viper venom diluted		A					
85635	Reptilase test		A					
85651	Rbc sed rate nonautomated		A					
85652	Rbc sed rate automated		A					
85660	RBC sickle cell test		A					
85670	Thrombin time plasma		A					
85675	Thrombin time titer		A					
85705	Thromboplastin inhibition		A					
85730	Thromboplastin time partial		A					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85732	Thromboplastin time partial		A					
85810	Blood viscosity examination		A					
85999	Hematology procedure		A					
86000	Agglutinins febrile		A					
86001	Allergen specific igg		A					
86003	Allergen specific IgE		A					
86005	Allergen specific IgE		A					
86021	WBC antibody identification		A					
86022	Platelet antibodies		A					
86023	Immunoglobulin assay		A					
86038	Antinuclear antibodies		A					
86039	Antinuclear antibodies (ANA)		A					
86060	Antistreptolysin o titer		A					
86063	Antistreptolysin o screen		A					
86077	Physician blood bank service		X	0433	0.2478	$17.07	$5.17	$3.42
86078	Physician blood bank service		X	0343	0.5296	$36.48	$10.84	$7.30
86079	Physician blood bank service		X	0433	0.2478	$17.07	$5.17	$3.42
86140	C-reactive protein		A					
86141	C-reactive protein hs		A					
86146	Glycoprotein antibody		A					
86147	Cardiolipin antibody		A					
86148	Phospholipid antibody		A					
86155	Chemotaxis assay		A					
86156	Cold agglutinin screen		A					
86157	Cold agglutinin titer		A					
86160	Complement antigen		A					
86161	Complement/function activity		A					
86162	Complement total (ch50)		A					
86171	Complement fixation each		A					
86185	Counterimmunoelectrophoresis		A					
86200	Ccp antibody		A					
86215	Deoxyribonuclease antibody		A					
86225	DNA antibody		A					
86226	Dna antibody single strand		A					
86235	Nuclear antigen antibody		A					
86243	Fc receptor		A					
86255	Fluorescent antibody screen		A					
86256	Fluorescent antibody titer		A					
86277	Growth hormone antibody		A					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86280	Hemagglutination inhibition		A					
86294	Immunoassay tumor qual		A					
86300	Immunoassay tumor ca 15-3		A					
86301	Immunoassay tumor ca 19-9		A					
86304	Immunoassay tumor ca 125		A					
86305	Human epididymis protein 4		A					
86308	Heterophile antibodies		A					
86309	Heterophile antibodies		A					
86310	Heterophile antibodies		A					
86316	Immunoassay tumor other		A					
86317	Immunoassay infectious agent		A					
86318	Immunoassay infectious agent		A					
86320	Serum immunoelectrophoresis		A					
86325	Other immunoelectrophoresis		A					
86327	Immunoelectrophoresis assay		A					
86329	Immunodiffusion		A					
86331	Immunodiffusion ouchterlony		A					
86332	Immune complex assay		A					
86334	Immunofix e-phoresis serum		A					
86335	Immunfix e-phorsis/urine/csf		A					
86336	Inhibin A		A					
86337	Insulin antibodies		A					
86340	Intrinsic factor antibody		A					
86341	Islet cell antibody		A					
86343	Leukocyte histamine release		A					
86344	Leukocyte phagocytosis		A					
86352	Cell function assay w/stim		A					
86353	Lymphocyte transformation		A					
86355	B cells total count		A					
86356	Mononuclear cell antigen		A					
86357	Nk cells total count		A					
86359	T cells total count		A					
86360	T cell absolute count/ratio		A					
86361	T cell absolute count		A					
86367	Stem cells total count		A					
86376	Microsomal antibody		A					
86378	Migration inhibitory factor		A					
86382	Neutralization test viral		A					
86384	Nitroblue tetrazolium dye		A					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86403	Particle agglutination test		A					
86406	Particle agglutination test		A					
86430	Rheumatoid factor test		A					
86431	Rheumatoid factor quant		A					
86480	Tb test cell immun measure		A					
86481	Tb ag response t-cell susp	NI	A					
86485	Skin test candida		X	0341	0.0809	$5.57	$2.09	$1.12
86486	Skin test nos antigen		X	0341	0.0809	$5.57	$2.09	$1.12
86490	Coccidioidomycosis skin test		X	0341	0.0809	$5.57	$2.09	$1.12
86510	Histoplasmosis skin test		X	0341	0.0809	$5.57	$2.09	$1.12
86580	TB intradermal test		X	0341	0.0809	$5.57	$2.09	$1.12
86590	Streptokinase antibody		A					
86592	Syphilis test non-trep qual		A					
86593	Syphilis test non-trep quant		A					
86602	Antinomyces antibody		A					
86603	Adenovirus antibody		A					
86606	Aspergillus antibody		A					
86609	Bacterium antibody		A					
86611	Bartonella antibody		A					
86612	Blastomyces antibody		A					
86615	Bordetella antibody		A					
86617	Lyme disease antibody		A					
86618	Lyme disease antibody		A					
86619	Borrelia antibody		A					
86622	Brucella antibody		A					
86625	Campylobacter antibody		A					
86628	Candida antibody		A					
86631	Chlamydia antibody		A					
86632	Chlamydia igm antibody		A					
86635	Coccidioides antibody		A					
86638	Q fever antibody		A					
86641	Cryptococcus antibody		A					
86644	CMV antibody		A					
86645	Cmv antibody igm		A					
86648	Diphtheria antibody		A					
86651	Encephalitis antibody		A					
86652	Encephalitis antibody		A					
86653	Encephalitis antibody		A					
86654	Encephalitis antibody		A					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86658	Enterovirus antibody		A					
86663	Epstein-barr antibody		A					
86664	Epstein-barr antibody		A					
86665	Epstein-barr antibody		A					
86666	Ehrlichia antibody		A					
86668	Francisella tularensis		A					
86671	Fungus antibody		A					
86674	Giardia lamblia antibody		A					
86677	Helicobacter pylori		A					
86682	Helminth antibody		A					
86684	Hemophilus influenza		A					
86687	Htlv-i antibody		A					
86688	Htlv-ii antibody		A					
86689	HTLV/HIV confirmatory test		A					
86692	Hepatitis delta agent		A					
86694	Herpes simplex test		A					
86695	Herpes simplex test		A					
86696	Herpes simplex type 2		A					
86698	Histoplasma		A					
86701	HIV-1		A					
86702	HIV-2		A					
86703	Hiv-1/hiv-2 single assay		A					
86704	Hep b core antibody total		A					
86705	Hep b core antibody igm		A					
86706	Hep b surface antibody		A					
86707	Hep be antibody		A					
86708	Hep a antibody total		A					
86709	Hep a antibody igm		A					
86710	Influenza virus antibody		A					
86713	Legionella antibody		A					
86717	Leishmania antibody		A					
86720	Leptospira antibody		A					
86723	Listeria monocytogenes ab		A					
86727	Lymph choriomeningitis ab		A					
86729	Lympho venereum antibody		A					
86732	Mucormycosis antibody		A					
86735	Mumps antibody		A					
86738	Mycoplasma antibody		A					
86741	Neisseria meningitidis		A					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86744	Nocardia antibody		A					
86747	Parvovirus antibody		A					
86750	Malaria antibody		A					
86753	Protozoa antibody nos		A					
86756	Respiratory virus antibody		A					
86757	Rickettsia antibody		A					
86759	Rotavirus antibody		A					
86762	Rubella antibody		A					
86765	Rubeola antibody		A					
86768	Salmonella antibody		A					
86771	Shigella antibody		A					
86774	Tetanus antibody		A					
86777	Toxoplasma antibody		A					
86778	Toxoplasma antibody igm		A					
86780	Treponema pallidum		A					
86784	Trichinella antibody		A					
86787	Varicella-zoster antibody		A					
86788	West nile virus ab igm		A					
86789	West nile virus antibody		A					
86790	Virus antibody nos		A					
86793	Yersinia antibody		A					
86800	Thyroglobulin antibody		A					
86803	Hepatitis c ab test		A					
86804	Hep c ab test confirm		A					
86805	Lymphocytotoxicity assay		A					
86806	Lymphocytotoxicity assay		A					
86807	Cytotoxic antibody screening		A					
86808	Cytotoxic antibody screening		A					
86812	Hla typing a b or c		A					
86813	Hla typing a b or c		A					
86816	Hla typing dr/dq		A					
86817	Hla typing dr/dq		A					
86821	Lymphocyte culture mixed		A					
86822	Lymphocyte culture primed		A					
86825	Hla x-math non-cytotoxic		A					
86826	Hla x-match noncytotoxc addl		A					
86849	Immunology procedure		A					
86850	RBC antibody screen		X	0345	0.2167	$14.93		$2.99
86860	RBC antibody elution		X	0346	0.3642	$25.08		$5.02

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86870	RBC antibody identification		X	0346	0.3642	$25.08	.	$5.02
86880	Coombs test direct		X	0409	0.1129	$7.78	$2.19	$1.56
86885	Coombs test indirect qual		X	0409	0.1129	$7.78	$2.19	$1.56
86886	Coombs test indirect titer		X	0409	0.1129	$7.78	$2.19	$1.56
86890	Autologous blood process		X	0347	0.7059	$48.62	.	$9.73
86891	Autologous blood op salvage		X	0345	0.2167	$14.93	.	$2.99
86900	Blood typing abo		X	0409	0.1129	$7.78	$2.19	$1.56
86901	Blood typing rh (d)		X	0409	0.1129	$7.78	$2.19	$1.56
86902	Blood type antigen donor ea	NI	X	0345	0.2167	$14.93	.	$2.99
86903	Blood typing, antigen screen	CH	D					
86904	Blood typing patient serum		X	0345	0.2167	$14.93	.	$2.99
86905	Blood typing rbc antigens		X	0345	0.2167	$14.93	.	$2.99
86906	Blood typing rh phenotype		X	0345	0.2167	$14.93	.	$2.99
86910	Blood typing paternity test		E					
86911	Blood typing antigen system		E					
86920	Compatibility test spin		X	0345	0.2167	$14.93	.	$2.99
86921	Compatibility test incubate		X	0345	0.2167	$14.93	.	$2.99
86922	Compatibility test antiglob		X	0346	0.3642	$25.08	.	$5.02
86923	Compatibility test electric		X	0345	0.2167	$14.93	.	$2.99
86927	Plasma fresh frozen		X	0345	0.2167	$14.93	.	$2.99
86930	Frozen blood prep		X	0347	0.7059	$48.62	.	$9.73
86931	Frozen blood thaw		X	0347	0.7059	$48.62	.	$9.73
86932	Frozen blood freeze/thaw		X	0347	0.7059	$48.62	.	$9.73
86940	Hemolysins/agglutinins auto		A					
86941	Hemolysins/agglutinins		A					
86945	Blood product/irradiation		X	0345	0.2167	$14.93	.	$2.99
86950	Leukacyte transfusion		X	0345	0.2167	$14.93	.	$2.99
86960	Vol reduction of blood/prod		X	0345	0.2167	$14.93	.	$2.99
86965	Pooling blood platelets		X	0346	0.3642	$25.08	.	$5.02
86970	RBC pretreatment		X	0345	0.2167	$14.93	.	$2.99
86971	RBC pretreatment		X	0345	0.2167	$14.93	.	$2.99
86972	RBC pretreatment		X	0345	0.2167	$14.93	.	$2.99
86975	Rbc pretreatment serum		X	0346	0.3642	$25.08	.	$5.02
86976	Rbc pretreatment serum		X	0345	0.2167	$14.93	.	$2.99
86977	Rbc pretreatment serum		X	0347	0.7059	$48.62	.	$9.73
86978	Rbc pretreatment serum		X	0346	0.3642	$25.08	.	$5.02
86985	Split blood or products		X	0345	0.2167	$14.93	.	$2.99
86999	Transfusion procedure		X	0345	0.2167	$14.93	.	$2.99
87001	Small animal inoculation		A					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87003	Small animal inoculation		A					
87015	Specimen concentration		A					
87040	Blood culture for bacteria		A					
87045	Feces culture bacteria		A					
87046	Stool cultr bacteria each		A					
87070	Culture bacteria other		A					
87071	Culture bacteri aerobic othr		A					
87073	Culture bacteria anaerobic		A					
87075	Cultr bacteria except blood		A					
87076	Culture anaerobe ident each		A					
87077	Culture aerobic identify		A					
87081	Culture screen only		A					
87084	Culture of specimen by kit		A					
87086	Urine culture/colony count		A					
87088	Urine bacteria culture		A					
87101	Skin fungi culture		A					
87102	Fungus isolation culture		A					
87103	Blood fungus culture		A					
87106	Fungi identification yeast		A					
87107	Fungi identification mold		A					
87109	Mycoplasma		A					
87110	Chlamydia culture		A					
87116	Mycobacteria culture		A					
87118	Mycobacteric identification		A					
87140	Culture type immunofluoresc		A					
87143	Culture typing glc/hplc		A					
87147	Culture type immunologic		A					
87149	Dna/rna direct probe		A					
87150	Dna/rna amplified probe		A					
87152	Culture type pulse field gel		A					
87153	Dna/rna sequencing		A					
87158	Culture typing added method		A					
87164	Dark field examination		A					
87166	Dark field examination		A					
87168	Macroscopic exam arthropod		A					
87169	Macroscopic exam parasite		A					
87172	Pinworm exam		A					
87176	Tissue homogenization cultr		A					
87177	Ova and parasites smears		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87181	Microbe susceptible diffuse		A					
87184	Microbe susceptible disk		A					
87185	Microbe susceptible enzyme		A					
87186	Microbe susceptible mic		A					
87187	Microbe susceptible mlc		A					
87188	Microbe suscept macrobroth		A					
87190	Microbe suscept mycobacteri		A					
87197	Bactericidal level serum		A					
87205	Smear gram stain		A					
87206	Smear fluorescent/acid stai		A					
87207	Smear special stain		A					
87209	Smear complex stain		A					
87210	Smear wet mount saline/ink		A					
87220	Tissue exam for fungi		A					
87230	Assay toxin or antitoxin		A					
87250	Virus inoculate eggs/animal		A					
87252	Virus inoculation tissue		A					
87253	Virus inoculate tissue addl		A					
87254	Virus inoculation shell via		A					
87255	Genet virus isolate hsv		A					
87260	Adenovirus ag if		A					
87265	Pertussis ag if		A					
87267	Enterovirus antibody dfa		A					
87269	Giardia ag if		A					
87270	Chlamydia trachomatis ag if		A					
87271	Cytomegalovirus dfa		A					
87272	Cryptosporidium ag if		A					
87273	Herpes simplex 2 ag if		A					
87274	Herpes simplex 1 ag if		A					
87275	Influenza b ag if		A					
87276	Influenza a ag if		A					
87277	Legionella micdadei ag if		A					
87278	Legion pneumophilia ag if		A					
87279	Parainfluenza ag if		A					
87280	Respiratory syncytial ag if		A					
87281	Pneumocystis carinii ag if		A					
87283	Rubeola ag if		A					
87285	Treponema pallidum ag if		A					
87290	Varicella zoster ag if		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87299	Antibody detection nos if		A					
87300	Ag detection polyval if		A					
87301	Adenovirus ag eia		A					
87305	Aspergillus ag eia		A					
87320	Chylmd trach ag eia		A					
87324	Clostridium ag eia		A					
87327	Cryptococcus neoform ag eia		A					
87328	Cryptosporidium ag eia		A					
87329	Giardia ag eia		A					
87332	Cytomegalovirus ag eia		A					
87335	E coli 0157 ag eia		A					
87336	Entamoeb hist dispr ag eia		A					
87337	Entamoeb hist group ag eia		A					
87338	Hpylori stool eia		A					
87339	H pylori ag eia		A					
87340	Hepatitis b surface ag eia		A					
87341	Hepatitis b surface ag eia		A					
87350	Hepatitis be ag eia		A					
87380	Hepatitis delta ag eia		A					
87385	Histoplasma capsul ag eia		A					
87390	Hiv-1 ag eia		A					
87391	Hiv-2 ag eia		A					
87400	Influenza a/b ag eia		A					
87420	Resp syncytial ag eia		A					
87425	Rotavirus ag eia		A					
87427	Shiga-like toxin ag eia		A					
87430	Strep a ag eia		A					
87449	Ag detect nos eia mult		A					
87450	Ag detect nos eia single		A					
87451	Ag detect polyval eia mult		A					
87470	Bartonella dna dir probe		A					
87471	Bartonella dna amp probe		A					
87472	Bartonella dna quant		A					
87475	Lyme dis dna dir probe		A					
87476	Lyme dis dna amp probe		A					
87477	Lyme dis dna quant		A					
87480	Candida dna dir probe		A					
87481	Candida dna amp probe		A					
87482	Candida dna quant		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87485	Chylmd pneum dna dir probe		A					
87486	Chylmd pneum dna amp probe		A					
87487	Chylmd pneum dna quant		A					
87490	Chylmd trach dna dir probe		A					
87491	Chylmd trach dna amp probe		A					
87492	Chylmd trach dna quant		A					
87493	C diff amplified probe		A					
87495	Cytomeg dna dir probe		A					
87496	Cytomeg dna amp probe		A					
87497	Cytomeg dna quant		A					
87498	Enterovirus dna amp probe		A					
87500	Vanomycin dna amp probe		A					
87501	Influenza dna amp prob 1+	NI	A					
87502	Influenza dna amp probe	NI	A					
87503	Influenza dna amp prob addl	NI	A					
87510	Gardner vag dna dir probe		A					
87511	Gardner vag dna amp probe		A					
87512	Gardner vag dna quant		A					
87515	Hepatitis b dna dir probe		A					
87516	Hepatitis b dna amp probe		A					
87517	Hepatitis b dna quant		A					
87520	Hepatitis c rna dir probe		A					
87521	Hepatitis c rna amp probe		A					
87522	Hepatitis c rna quant		A					
87525	Hepatitis g dna dir probe		A					
87526	Hepatitis g dna amp probe		A					
87527	Hepatitis g dna quant		A					
87528	Hsv dna dir probe		A					
87529	Hsv dna amp probe		A					
87530	Hsv dna quant		A					
87531	Hhv-6 dna dir probe		A					
87532	Hhv-6 dna amp probe		A					
87533	Hhv-6 dna quant		A					
87534	Hiv-1 dna dir probe		A					
87535	Hiv-1 dna amp probe		A					
87536	Hiv-1 dna quant		A					
87537	Hiv-2 dna dir probe		A					
87538	Hiv-2 dna amp probe		A					
87539	Hiv-2 dna quant		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87540	Legion pneumo dna dir prob		A					
87541	Legion pneumo dna amp prob		A					
87542	Legion pneumo dna quant		A					
87550	Mycobacteria dna dir probe		A					
87551	Mycobacteria dna amp probe		A					
87552	Mycobacteria dna quant		A					
87555	M.tuberculo dna dir probe		A					
87556	M.tuberculo dna amp probe		A					
87557	M.tuberculo dna quant		A					
87560	M.avium-intra dna dir prob		A					
87561	M.avium-intra dna amp prob		A					
87562	M.avium-intra dna quant		A					
87580	M.pneumon dna dir probe		A					
87581	M.pneumon dna amp probe		A					
87582	M.pneumon dna quant		A					
87590	N.gonorrhoeae dna dir prob		A					
87591	N.gonorrhoeae dna amp prob		A					
87592	N.gonorrhoeae dna quant		A					
87620	Hpv dna dir probe		A					
87621	Hpv dna amp probe		A					
87622	Hpv dna quant		A					
87640	Staph a dna amp probe		A					
87641	Mr-staph dna amp probe		A					
87650	Strep a dna dir probe		A					
87651	Strep a dna amp probe		A					
87652	Strep a dna quant		A					
87653	Strep b dna amp probe		A					
87660	Trichomonas vagin dir probe		A					
87797	Detect agent nos dna dir		A					
87798	Detect agent nos dna amp		A					
87799	Detect agent nos dna quant		A					
87800	Detect agnt mult dna direc		A					
87801	Detect agnt mult dna ampli		A					
87802	Strep b assay w/optic		A					
87803	Clostridium toxin a w/optic		A					
87804	Influenza assay w/optic		A					
87807	Rsv assay w/optic		A					
87808	Trichomonas assay w/optic		A					
87809	Adenovirus assay w/optic		A					

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87810	Chylmd trach assay w/optic		A					
87850	N. gonorrhoeae assay w/optic		A					
87880	Strep a assay w/optic		A					
87899	Agent nos assay w/optic		A					
87900	Phenotype infect agent drug		A					
87901	Genotype dna hiv reverse t		A					
87902	Genotype dna hepatitis c		A					
87903	Phenotype dna hiv w/culture		A					
87904	Phenotype dna hiv w/clt add		A					
87905	Sialidase enzyme assay		A					
87906	Genotype dna hiv reverse t	NI	A					
87999	Microbiology procedure		A					
88000	Autopsy (necropsy) gross		E					
88005	Autopsy (necropsy) gross		E					
88007	Autopsy (necropsy) gross		E					
88012	Autopsy (necropsy) gross		E					
88014	Autopsy (necropsy) gross		E					
88016	Autopsy (necropsy) gross		E					
88020	Autopsy (necropsy) complete		E					
88025	Autopsy (necropsy) complete		E					
88027	Autopsy (necropsy) complete		E					
88028	Autopsy (necropsy) complete		E					
88029	Autopsy (necropsy) complete		E					
88036	Limited autopsy		E					
88037	Limited autopsy		E					
88040	Forensic autopsy (necropsy)		E					
88045	Coroners autopsy (necropsy)		E					
88099	Necropsy (autopsy) procedure		E					
88104	Cytopath fl nongyn smears		X	0433	0.2478	$17.07	$5.17	$3.42
88106	Cytopath fl nongyn filter		X	0433	0.2478	$17.07	$5.17	$3.42
88107	Cytopath fl nongyn sm/fltr		X	0343	0.5296	$36.48	$10.84	$7.30
88108	Cytopath concentrate tech		X	0433	0.2478	$17.07	$5.17	$3.42
88112	Cytopath cell enhance tech		X	0343	0.5296	$36.48	$10.84	$7.30
88120	Cytp urne 3-5 probes ea spec	NI	X	0344	0.8191	$56.42	$15.56	$11.29
88121	Cytp urine 3-5 probes cmptr	NI	X	0344	0.8191	$56.42	$15.56	$11.29
88125	Forensic cytopathology		X	0433	0.2478	$17.07	$5.17	$3.42
88130	Sex chromatin identification		A					
88140	Sex chromatin identification		A					
88141	Cytopath c/v interpret		N					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88142	Cytopath c/v thin layer		A					
88143	Cytopath c/v thin layer redo		A					
88147	Cytopath c/v automated		A					
88148	Cytopath c/v auto rescreen		A					
88150	Cytopath c/v manual		A					
88152	Cytopath c/v auto redo		A					
88153	Cytopath c/v redo		A					
88154	Cytopath c/v select		A					
88155	Cytopath c/v index add-on		A					
88160	Cytopath smear other source		X	0433	0.2478	$17.07	$5.17	$3.42
88161	Cytopath smear other source		X	0433	0.2478	$17.07	$5.17	$3.42
88162	Cytopath smear other source		X	0343	0.5296	$36.48	$10.84	$7.30
88164	Cytopath tbs c/v manual		A					
88165	Cytopath tbs c/v redo		A					
88166	Cytopath tbs c/v auto redo		A					
88167	Cytopath tbs c/v select		A					
88172	Cytp dx eval fna 1st ea site	NI	X	0433	0.2478	$17.07	$5.17	$3.42
88173	Cytopath eval fna report		X	0343	0.5296	$36.48	$10.84	$7.30
88174	Cytopath c/v auto in fluid		A					
88175	Cytopath c/v auto fluid redo		A					
88177	Cytp c/v auto thin lyr addl	NI	X	0342	0.1603	$11.04	.	$2.21
88182	Cell marker study		X	0343	0.5296	$36.48	$10.84	$7.30
88184	Flowcytometry/ tc 1 marker		X	0433	0.2478	$17.07	$5.17	$3.42
88185	Flowcytometry/tc add-on		X	0433	0.2478	$17.07	$5.17	$3.42
88187	Flowcytometry/read 2-8		X	0342	0.1603	$11.04	.	$2.21
88188	Flowcytometry/read 9-15		X	0343	0.5296	$36.48	$10.84	$7.30
88189	Flowcytometry/read 16 & >		X	0343	0.5296	$36.48	$10.84	$7.30
88199	Cytopathology procedure		X	0342	0.1603	$11.04	.	$2.21
88230	Tissue culture lymphocyte		A					
88233	Tissue culture skin/biopsy		A					
88235	Tissue culture placenta		A					
88237	Tissue culture bone marrow		A					
88239	Tissue culture tumor		A					
88240	Cell cryopreserve/storage		A					
88241	Frozen cell preparation		A					
88245	Chromosome analysis 20-25		A					
88248	Chromosome analysis 50-100		A					
88249	Chromosome analysis 100		A					
88261	Chromosome analysis 5		A					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88262	Chromosome analysis 15-20		A					
88263	Chromosome analysis 45		A					
88264	Chromosome analysis 20-25		A					
88267	Chromosome analys placenta		A					
88269	Chromosome analys amniotic		A					
88271	Cytogenetics dna probe		A					
88272	Cytogenetics 3-5		A					
88273	Cytogenetics 10-30		A					
88274	Cytogenetics 25-99		A					
88275	Cytogenetics 100-300		A					
88280	Chromosome karyotype study		A					
88283	Chromosome banding study		A					
88285	Chromosome count additional		A					
88289	Chromosome study additional		A					
88291	Cyto/molecular report		M					
88299	Cytogenetic study		X	0342	0.1603	$11.04	.	$2.21
88300	Surgical path gross		X	0433	0.2478	$17.07	$5.17	$3.42
88302	Tissue exam by pathologist		X	0433	0.2478	$17.07	$5.17	$3.42
88304	Tissue exam by pathologist		X	0343	0.5296	$36.48	$10.84	$7.30
88305	Tissue exam by pathologist		X	0343	0.5296	$36.48	$10.84	$7.30
88307	Tissue exam by pathologist		X	0344	0.8191	$56.42	$15.56	$11.29
88309	Tissue exam by pathologist		X	0344	0.8191	$56.42	$15.56	$11.29
88311	Decalcify tissue		X	0342	0.1603	$11.04	.	$2.21
88312	Special stains group 1		X	0433	0.2478	$17.07	$5.17	$3.42
88313	Special stains group 2		X	0433	0.2478	$17.07	$5.17	$3.42
88314	Histochemical stains add-on		X	0433	0.2478	$17.07	$5.17	$3.42
88318	Chemical histochemistry		X	0433	0.2478	$17.07	$5.17	$3.42
88319	Enzyme histochemistry	CH	X	0343	0.5296	$36.48	$10.84	$7.30
88321	Microslide consultation		X	0433	0.2478	$17.07	$5.17	$3.42
88323	Microslide consultation		X	0343	0.5296	$36.48	$10.84	$7.30
88325	Comprehensive review of data		X	0344	0.8191	$56.42	$15.56	$11.29
88329	Path consult introp		X	0433	0.2478	$17.07	$5.17	$3.42
88331	Path consult intraop 1 bloc		X	0343	0.5296	$36.48	$10.84	$7.30
88332	Path consult intraop addl		X	0433	0.2478	$17.07	$5.17	$3.42
88333	Intraop cyto path consult 1		X	0433	0.2478	$17.07	$5.17	$3.42
88334	Intraop cyto path consult 2		X	0433	0.2478	$17.07	$5.17	$3.42
88342	Immunohistochemistry		X	0343	0.5296	$36.48	$10.84	$7.30
88346	Immunofluorescent study		X	0343	0.5296	$36.48	$10.84	$7.30
88347	Immunofluorescent study		X	0343	0.5296	$36.48	$10.84	$7.30

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88348	Electron microscopy		X	0661	2.1892	$150.78	.	$30.16
88349	Scanning electron microscopy		X	0661	2.1892	$150.78	.	$30.16
88355	Analysis skeletal muscle		X	0343	0.5296	$36.48	$10.84	$7.30
88356	Analysis nerve		X	0344	0.8191	$56.42	$15.56	$11.29
88358	Analysis tumor		X	0343	0.5296	$36.48	$10.84	$7.30
88360	Tumor immunohistochem/manual		X	0343	0.5296	$36.48	$10.84	$7.30
88361	Tumor immunohistochem/comput		X	0344	0.8191	$56.42	$15.56	$11.29
88362	Nerve teasing preparations		X	0344	0.8191	$56.42	$15.56	$11.29
88363	Xm archive tissue molec anal	NI	X	0342	0.1603	$11.04	.	$2.21
88365	Insitu hybridization (fish)		X	0344	0.8191	$56.42	$15.56	$11.29
88367	Insitu hybridization auto	CH	X	0343	0.5296	$36.48	$10.84	$7.30
88368	Insitu hybridization manual		X	0344	0.8191	$56.42	$15.56	$11.29
88371	Protein western blot tissue		A					
88372	Protein analysis w/probe		A					
88380	Microdissection laser		N					
88381	Microdissection manual		N					
88384	Eval molecular probes 11-50		X	0433	0.2478	$17.07	$5.17	$3.42
88385	Eval molecul probes 51-250		X	0343	0.5296	$36.48	$10.84	$7.30
88386	Eval molecul probes 251-500		X	0344	0.8191	$56.42	$15.56	$11.29
88387	Tiss exam molecular study		N					
88388	Tiss ex molecul study add-on		N					
88399	Surgical pathology procedure		X	0342	0.1603	$11.04	.	$2.21
88720	Bilirubin total transcut		A					
88738	Hgb quant transcutaneous		A					
88740	Transcutaneous carboxyhb		A					
88741	Transcutaneous methb		A					
88749	In vivo lab service	NI	A					
89049	Chct for mal hyperthermia		X	0342	0.1603	$11.04	.	$2.21
89050	Body fluid cell count		A					
89051	Body fluid cell count		A					
89055	Leukocyte assessment fecal		A					
89060	Exam synovial fluid crystals		A					
89100	Sample intestinal contents	CH	D					
89105	Sample intestinal contents	CH	D					
89125	Specimen fat stain		A					
89130	Sample stomach contents	CH	D					
89132	Sample stomach contents	CH	D					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
89135	Sample stomach contents	CH	D					
89136	Sample stomach contents	CH	D					
89140	Sample stomach contents	CH	D					
89141	Sample stomach contents	CH	D					
89160	Exam feces for meat fibers		A					
89190	Nasal smear for eosinophils		A					
89220	Sputum specimen collection		X	0433	0.2478	$17.07	$5.17	$3.42
89225	Starch granules, feces	CH	D					
89230	Collect sweat for test		X	0343	0.5296	$36.48	$10.84	$7.30
89235	Water load test	CH	D					
89240	Pathology lab procedure		X	0342	0.1603	$11.04	.	$2.21
89250	Cultr oocyte/embryo <4 days		X	0344	0.8191	$56.42	$15.56	$11.29
89251	Cultr oocyte/embryo <4 days		X	0344	0.8191	$56.42	$15.56	$11.29
89253	Embryo hatching		X	0344	0.8191	$56.42	$15.56	$11.29
89254	Oocyte identification		X	0344	0.8191	$56.42	$15.56	$11.29
89255	Prepare embryo for transfer		X	0344	0.8191	$56.42	$15.56	$11.29
89257	Sperm identification	CH	X	0343	0.5296	$36.48	$10.84	$7.30
89258	Cryopreservation embryo(s)		X	0344	0.8191	$56.42	$15.56	$11.29
89259	Cryopreservation sperm	CH	X	0343	0.5296	$36.48	$10.84	$7.30
89260	Sperm isolation simple	CH	X	0343	0.5296	$36.48	$10.84	$7.30
89261	Sperm isolation complex	CH	X	0343	0.5296	$36.48	$10.84	$7.30
89264	Identify sperm tissue		X	0344	0.8191	$56.42	$15.56	$11.29
89268	Insemination of oocytes		X	0344	0.8191	$56.42	$15.56	$11.29
89272	Extended culture of oocytes		X	0344	0.8191	$56.42	$15.56	$11.29
89280	Assist oocyte fertilization		X	0344	0.8191	$56.42	$15.56	$11.29
89281	Assist oocyte fertilization		X	0344	0.8191	$56.42	$15.56	$11.29
89290	Biopsy oocyte polar body		X	0344	0.8191	$56.42	$15.56	$11.29
89291	Biopsy oocyte polar body		X	0344	0.8191	$56.42	$15.56	$11.29
89300	Semen analysis w/huhner		A					
89310	Semen analysis w/count		A					
89320	Semen anal vol/count/mot		A					
89321	Semen anal sperm detection		A					
89322	Semen anal strict criteria		A					
89325	Sperm antibody test		A					
89329	Sperm evaluation test		A					
89330	Evaluation cervical mucus		A					
89331	Retrograde ejaculation anal		A					
89335	Cryopreserve testicular tiss		X	0344	0.8191	$56.42	$15.56	$11.29
89342	Storage/year embryo(s)		X	0344	0.8191	$56.42	$15.56	$11.29

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
89343	Storage/year sperm/semen		X	0344	0.8191	$56.42	$15.56	$11.29
89344	Storage/year reprod tissue		X	0344	0.8191	$56.42	$15.56	$11.29
89346	Storage/year oocyte(s)		X	0344	0.8191	$56.42	$15.56	$11.29
89352	Thawing cryopresrved embryo		X	0344	0.8191	$56.42	$15.56	$11.29
89353	Thawing cryopresrved sperm		X	0344	0.8191	$56.42	$15.56	$11.29
89354	Thaw cryoprsvrd reprod tiss		X	0344	0.8191	$56.42	$15.56	$11.29
89356	Thawing cryopresrved oocyte		X	0344	0.8191	$56.42	$15.56	$11.29
89398	Unlisted reprod med lab proc		X	0342	0.1603	$11.04	.	$2.21
90281	Human ig im		E					
90283	Human ig iv		E					
90284	Human ig sc		E					
90287	Botulinum antitoxin		E					
90288	Botulism ig iv		E					
90291	Cmv ig iv		E					
90296	Diphtheria antitoxin		E					
90371	Hep b ig im		K	1630	.	$114.18	.	$22.84
90375	Rabies ig im/sc		K	9133	.	$165.12	.	$33.03
90376	Rabies ig heat treated		K	9134	.	$159.71	.	$31.95
90378	Rsv mab im 50mg		K	9003	.	$74.65	.	$14.93
90384	Rh ig full-dose im		E					
90385	Rh ig minidose im		N					
90386	Rh ig iv		E					
90389	Tetanus ig im		E					
90393	Vaccina ig im		E					
90396	Varicella-zoster ig im		K	9135	.	$129.48	.	$25.90
90399	Immune globulin		E					
90460	Imadm any route 1st vac/tox	NI	B					
90461	Inadm any route addl vac/tox	NI	B					
90465	Immune admin 1 inj, < 8 yrs	CH	D					
90466	Immune admin addl inj, < 8 y	CH	D					
90467	Immune admin o or n, < 8 yrs	CH	D					
90468	Immune admin o/n, addl < 8 y	CH	D					
90470	Immune admin H1N1 im/nasal		E					
90471	Immunization admin		S	0436	0.3826	$26.35	.	$5.27
90472	Immunization admin each add		S	0436	0.3826	$26.35	.	$5.27
90473	Immune admin oral/nasal		S	0436	0.3826	$26.35	.	$5.27
90474	Immune admin oral/nasal addl		S	0436	0.3826	$26.35	.	$5.27
90476	Adenovirus vaccine type 4		K	1254	.	$23.24	.	$4.65
90477	Adenovirus vaccine type 7		E					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90581	Anthrax vaccine sc		E					
90585	Bcg vaccine percut		K	9137	.	$110.93	.	$22.19
90586	Bcg vaccine intravesical		B					
90632	Hep a vaccine adult im		N					
90633	Hep a vacc ped/adol 2 dose		N					
90634	Hep a vacc ped/adol 3 dose		N					
90636	Hep a/hep b vacc adult im		N					
90644	Meningoccl hib vac 4 dose im		E					
90645	Hib vaccine hboc im		N					
90646	Hib vaccine prp-d im		N					
90647	Hib vaccine prp-omp im		N					
90648	Hib vaccine prp-t im		N					
90649	Hpv vaccine 4 valent im		M					
90650	Hpv vaccine 2 valent im		M					
90654	Flu vaccine no preserv, ID	NI	E					
90655	Flu vaccine no preserv 6-35m		L					
90656	Flu vaccine no preserv 3 & >		L					
90657	Flu vaccine 3 yrs im		L					
90658	Flu vaccine 3 yrs & > im	CH	E					
90660	Flu vaccine nasal		L					
90661	Flu vacc cell cult prsv free		E					
90662	Flu vacc prsv free inc antig	CH	L					
90663	Flu vacc pandemic H1N1		E					
90664	Flu vacc pandemic intranasal		E					
90665	Lyme disease vaccine im	CH	N					
90666	Flu vac pandem prsrv free im		E					
90667	Flu vac pandemic adjuvant im		E					
90668	Flu vac pandemic splt im		E					
90669	Pneumococcal vacc 7 val im		L					
90670	Pneumococcal vacc 13 val im	CH	L					
90675	Rabies vaccine im		K	9139	.	$200.66	.	$40.14
90676	Rabies vaccine id		K	9140	.	$107.83	.	$21.57
90680	Rotovirus vacc 3 dose oral		K	1255	.	$73.07	.	$14.62
90681	Rotavirus vacc 2 dose oral		K	1239	.	$101.53	.	$20.31
90690	Typhoid vaccine oral		N					
90691	Typhoid vaccine im		N					
90692	Typhoid vaccine h-p sc/id		N					
90693	Typhoid vaccine akd sc		B					
90696	Dtap-ipv vacc 4-6 yr im		N					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90698	Dtap-hib-ip vaccine im		N					
90700	Dtap vaccine < 7 yrs im		N					
90701	Dtp vaccine im		N					
90702	Dt vaccine < 7 im		N					
90703	Tetanus vaccine im		N					
90704	Mumps vaccine sc		N					
90705	Measles vaccine sc		N					
90706	Rubella vaccine sc		N					
90707	Mmr vaccine sc		N					
90708	Measles-rubella vaccine sc		N					
90710	Mmrv vaccine sc		N					
90712	Oral poliovirus vaccine		N					
90713	Poliovirus ipv sc/im		N					
90714	Td vaccine no prsrv >/= 7 im		N					
90715	Tdap vaccine >7 im		N					
90716	Chicken pox vaccine sc		M					
90717	Yellow fever vaccine sc		N					
90718	Td vaccine > 7 im		N					
90719	Diphtheria vaccine im		N					
90720	Dtp/hib vaccine im		N					
90721	Dtap/hib vaccine im		N					
90723	Dtap-hep b-ipv vaccine im		E					
90725	Cholera vaccine injectable	CH	E					
90727	Plague vaccine im		E					
90732	Pneumococcal vaccine		L					
90733	Meningococcal vaccine sc		K	9143	.	$102.44	.	$20.49
90734	Meningococcal vaccine im		K	9145	.	$95.06	.	$19.02
90735	Encephalitis vaccine sc		K	9144	.	$101.12	.	$20.23
90736	Zoster vacc sc		M					
90738	Inactivated je vacc im		M					
90740	Hepb vacc ill pat 3 dose im		F					
90743	Hep b vacc adol 2 dose im		F					
90744	Hepb vacc ped/adol 3 dose im		F					
90746	Hep b vaccine adult im		F					
90747	Hepb vacc ill pat 4 dose im		F					
90748	Hep b/hib vaccine im		E					
90749	Vaccine toxoid		N					
90801	Psy dx interview		Q3	0323	1.6414	$113.05	.	$22.61
90802	Intac psy dx interview		Q3	0323	1.6414	$113.05	.	$22.61

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90804	Psytx office 20-30 min		Q3	0322	1.2012	$82.73	.	$16.55
90805	Psytx off 20-30 min w/e&m		Q3	0322	1.2012	$82.73	.	$16.55
90806	Psytx off 45-50 min		Q3	0323	1.6414	$113.05	.	$22.61
90807	Psytx off 45-50 min w/e&m		Q3	0323	1.6414	$113.05	.	$22.61
90808	Psytx office 75-80 min		Q3	0323	1.6414	$113.05	.	$22.61
90809	Psytx off 75-80 w/e&m		Q3	0323	1.6414	$113.05	.	$22.61
90810	Intac psytx off 20-30 min		Q3	0322	1.2012	$82.73	.	$16.55
90811	Intac psytx 20-30 w/e&m		Q3	0322	1.2012	$82.73	.	$16.55
90812	Intac psytx off 45-50 min		Q3	0323	1.6414	$113.05	.	$22.61
90813	Intac psytx 45-50 min w/e&m		Q3	0323	1.6414	$113.05	.	$22.61
90814	Intac psytx off 75-80 min		Q3	0323	1.6414	$113.05	.	$22.61
90815	Intac psytx 75-80 w/e&m		Q3	0323	1.6414	$113.05	.	$22.61
90816	Psytx hosp 20-30 min		P					
90817	Psytx hosp 20-30 min w/e&m		P					
90818	Psytx hosp 45-50 min		P					
90819	Psytx hosp 45-50 min w/e&m		P					
90821	Psytx hosp 75-80 min		P					
90822	Psytx hosp 75-80 min w/e&m		P					
90823	Intac psytx hosp 20-30 min		P					
90824	Intac psytx hsp 20-30 w/e&m		P					
90826	Intac psytx hosp 45-50 min		P					
90827	Intac psytx hsp 45-50 w/e&m		P					
90828	Intac psytx hosp 75-80 min		P					
90829	Intac psytx hsp 75-80 w/e&m		P					
90845	Psychoanalysis		Q3	0323	1.6414	$113.05	.	$22.61
90846	Family psytx w/o patient		Q3	0324	1.8703	$128.82	.	$25.77
90847	Family psytx w/patient		Q3	0324	1.8703	$128.82	.	$25.77
90849	Multiple family group psytx		Q3	0325	0.7967	$54.87	$11.70	$10.98
90853	Group psychotherapy		Q3	0325	0.7967	$54.87	$11.70	$10.98
90857	Intac group psytx		Q3	0325	0.7967	$54.87	$11.70	$10.98
90862	Medication management	CH	Q3	0605	1.0908	$75.13	.	$15.03
90865	Narcosynthesis		Q3	0323	1.6414	$113.05	.	$22.61
90867	Tcranial magn stim tx plan	NI	S	0216	2.7030	$186.17	.	$37.24
90868	Tcranial magn stim tx deli	NI	S	0216	2.7030	$186.17	.	$37.24
90870	Electroconvulsive therapy		S	0320	5.8800	$404.99	.	$81.00
90875	Psychophysiological therapy		E					
90876	Psychophysiological therapy		E					
90880	Hypnotherapy		Q3	0323	1.6414	$113.05	.	$22.61
90882	Environmental manipulation		E					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90885	Psy evaluation of records		N					
90887	Consultation with family		N					
90889	Preparation of report		N					
90899	Psychiatric service/therapy		Q3	0322	1.2012	$82.73	.	$16.55
90901	Biofeedback train any meth		A					
90911	Biofeedback peri/uro/rectal		T	0126	1.1110	$76.52	$16.21	$15.31
90935	Hemodialysis one evaluation		S	0170	6.9317	$477.43	.	$95.49
90937	Hemodialysis repeated eval		B					
90940	Hemodialysis access study		N					
90945	Dialysis one evaluation		V	0608	2.4525	$168.92	.	$33.79
90947	Dialysis repeated eval		B					
90951	Esrd serv 4 visits p mo <2		M					
90952	Esrd serv 2-3 vsts p mo <2		M					
90953	Esrd serv 1 visit p mo <2		M					
90954	Esrd serv 4 vsts p mo 2-11		M					
90955	Esrd srv 2-3 vsts p mo 2-11		M					
90956	Esrd srv 1 visit p mo 2-11		M					
90957	Esrd srv 4 vsts p mo 12-19		M					
90958	Esrd srv 2-3 vsts p mo 12-19		M					
90959	Esrd serv 1 vst p mo 12-19		M					
90960	Esrd srv 4 visits p mo 20+		M					
90961	Esrd srv 2-3 vsts p mo 20+		M					
90962	Esrd serv 1 visit p mo 20+		M					
90963	Esrd home pt serv p mo <2		M					
90964	Esrd home pt serv p mo 2-11		M					
90965	Esrd home pt serv p mo 12-19		M					
90966	Esrd home pt serv p mo 20+		M					
90967	Esrd home pt serv p day <2		M					
90968	Esrd home pt srv p day 2-11		M					
90969	Esrd home pt srv p day 12-19		M					
90970	Esrd home pt serv p day 20+		M					
90989	Dialysis training complete		B					
90993	Dialysis training incompl		B					
90997	Hemoperfusion		B					
90999	Dialysis procedure		B					
91000	Esophageal intubation	CH	D					
91010	Esophagus motility study		X	0361	4.1013	$282.48	$83.23	$56.50
91011	Esophagus motility study	CH	D					
91012	Esophagus motility study	CH	D					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
91013	Esophgl motil w/stim/perfus	NI	X	0361	4.1013	$282.48	$83.23	$56.50
91020	Gastric motility studies		X	0361	4.1013	$282.48	$83.23	$56.50
91022	Duodenal motility study		X	0361	4.1013	$282.48	$83.23	$56.50
91030	Acid perfusion of esophagus		X	0361	4.1013	$282.48	$83.23	$56.50
91034	Gastroesophageal reflux test		X	0361	4.1013	$282.48	$83.23	$56.50
91035	G-esoph reflx tst w/electrod		X	0361	4.1013	$282.48	$83.23	$56.50
91037	Esoph imped function test	CH	X	0360	1.7442	$120.13	$33.88	$24.03
91038	Esoph imped funct test > 1h		X	0361	4.1013	$282.48	$83.23	$56.50
91040	Esoph balloon distension tst		X	0360	1.7442	$120.13	$33.88	$24.03
91052	Gastric analysis test	CH	D					
91055	Gastric intubation for smear	CH	D					
91065	Breath hydrogen test		X	0360	1.7442	$120.13	$33.88	$24.03
91105	Gastric intubation treatment	CH	D					
91110	Gi tract capsule endoscopy		T	0142	10.1857	$701.55	$152.78	$140.31
91111	Esophageal capsule endoscopy		T	0141	8.8816	$611.73	$143.38	$122.35
91117	Colon motility 6 hr study	NI	T	0156	3.2116	$221.20	.	$44.24
91120	Rectal sensation test		T	0126	1.1110	$76.52	$16.21	$15.31
91122	Anal pressure record		T	0156	3.2116	$221.20	.	$44.24
91123	Irrigate fecal impaction	CH	D					
91132	Electrogastrography		X	0360	1.7442	$120.13	$33.88	$24.03
91133	Electrogastrography w/test		X	0360	1.7442	$120.13	$33.88	$24.03
91299	Gastroenterology procedure		X	0360	1.7442	$120.13	$33.88	$24.03
92002	Eye exam new patient		V	0606	1.4477	$99.71	.	$19.95
92004	Eye exam new patient		V	0606	1.4477	$99.71	.	$19.95
92012	Eye exam established pat	CH	V	0605	1.0908	$75.13	.	$15.03
92014	Eye exam & treatment		V	0605	1.0908	$75.13	.	$15.03
92015	Refraction		E					
92018	New eye exam & treatment		T	0699	16.7862	$1,156.17	.	$231.24
92019	Eye exam & treatment		T	0699	16.7862	$1,156.17	.	$231.24
92020	Special eye evaluation		S	0230	0.6053	$41.69	.	$8.34
92025	Corneal topography		S	0698	0.9697	$66.79	.	$13.36
92060	Special eye evaluation		S	0698	0.9697	$66.79	.	$13.36
92065	Orthoptic/pleoptic training		S	0698	0.9697	$66.79	.	$13.36
92070	Fitting of contact lens		N					
92081	Visual field examination(s)		S	0230	0.6053	$41.69	.	$8.34
92082	Visual field examination(s)		S	0698	0.9697	$66.79	.	$13.36
92083	Visual field examination(s)		S	0698	0.9697	$66.79	.	$13.36
92100	Serial tonometry exam(s)		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92120	Tonography & eye evaluation		S	0698	0.9697	$66.79	.	$13.36
92130	Water provocation tonography		S	0230	0.6053	$41.69	.	$8.34
92132	Cmptr ophth dx img ant segmt	NI	S	0230	0.6053	$41.69	.	$8.34
92133	Cmptr ophth img optic nerve	NI	S	0230	0.6053	$41.69	.	$8.34
92134	Cptr ophth dx img post segmt	NI	S	0230	0.6053	$41.69	.	$8.34
92135	Ophth dx imaging post seg	CH	D					
92136	Ophthalmic biometry		S	0698	0.9697	$66.79	.	$13.36
92140	Glaucoma provocative tests		S	0230	0.6053	$41.69	.	$8.34
92225	Special eye exam initial		S	0230	0.6053	$41.69	.	$8.34
92226	Special eye exam subsequent		S	0698	0.9697	$66.79	.	$13.36
92227	Remote dx retinal imaging	NI	X	0035	0.2674	$18.42	.	$3.69
92228	Remote retinal imaging mgmt	NI	X	0035	0.2674	$18.42	.	$3.69
92230	Eye exam with photos		S	0231	2.3078	$158.95	.	$31.79
92235	Eye exam with photos		S	0231	2.3078	$158.95	.	$31.79
92240	Icg angiography		S	0231	2.3078	$158.95	.	$31.79
92250	Eye exam with photos		S	0698	0.9697	$66.79	.	$13.36
92260	Ophthalmoscopy/dynamometry		S	0230	0.6053	$41.69	.	$8.34
92265	Eye muscle evaluation		S	0698	0.9697	$66.79	.	$13.36
92270	Electro-oculography		S	0230	0.6053	$41.69	.	$8.34
92275	Electroretinography		S	0231	2.3078	$158.95	.	$31.79
92283	Color vision examination		S	0230	0.6053	$41.69	.	$8.34
92284	Dark adaptation eye exam		S	0698	0.9697	$66.79	.	$13.36
92285	Eye photography		S	0698	0.9697	$66.79	.	$13.36
92286	Internal eye photography		S	0231	2.3078	$158.95	.	$31.79
92287	Internal eye photography		S	0231	2.3078	$158.95	.	$31.79
92310	Contact lens fitting		E					
92311	Contact lens fitting		S	0698	0.9697	$66.79	.	$13.36
92312	Contact lens fitting		S	0698	0.9697	$66.79	.	$13.36
92313	Contact lens fitting		S	0230	0.6053	$41.69	.	$8.34
92314	Prescription of contact lens		E					
92315	Prescription of contact lens		S	0230	0.6053	$41.69	.	$8.34
92316	Prescription of contact lens		S	0698	0.9697	$66.79	.	$13.36
92317	Prescription of contact lens		S	0230	0.6053	$41.69	.	$8.34
92325	Modification of contact lens		S	0230	0.6053	$41.69	.	$8.34
92326	Replacement of contact lens		S	0698	0.9697	$66.79	.	$13.36
92340	Fitting of spectacles		E					
92341	Fitting of spectacles		E					
92342	Fitting of spectacles		E					
92352	Special spectacles fitting		S	0698	0.9697	$66.79	.	$13.36

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92353	Special spectacles fitting		S	0230	0.6053	$41.69	.	$8.34
92354	Special spectacles fitting		S	0230	0.6053	$41.69	.	$8.34
92355	Special spectacles fitting		S	0230	0.6053	$41.69	.	$8.34
92358	Eye prosthesis service		S	0230	0.6053	$41.69	.	$8.34
92370	Repair & adjust spectacles		E					
92371	Repair & adjust spectacles		S	0230	0.6053	$41.69	.	$8.34
92499	Eye service or procedure		S	0230	0.6053	$41.69	.	$8.34
92502	Ear and throat examination		T	0251	3.5538	$244.77	.	$48.96
92504	Ear microscopy examination		N					
92506	Speech/hearing evaluation		A					
92507	Speech/hearing therapy		A					
92508	Speech/hearing therapy		A					
92511	Nasopharyngoscopy		T	0071	0.9297	$64.03	.	$12.81
92512	Nasal function studies		X	0363	0.9181	$63.24	$17.10	$12.65
92516	Facial nerve function test		X	0660	1.4693	$101.20	$27.10	$20.24
92520	Laryngeal function studies		X	0660	1.4693	$101.20	$27.10	$20.24
92526	Oral function therapy		A					
92531	Spontaneous nystagmus study		N					
92532	Positional nystagmus test		N					
92533	Caloric vestibular test		N					
92534	Optokinetic nystagmus test		N					
92540	Basic vestibular evaluation		X	0660	1.4693	$101.20	$27.10	$20.24
92541	Spontaneous nystagmus test		X	0363	0.9181	$63.24	$17.10	$12.65
92542	Positional nystagmus test		X	0363	0.9181	$63.24	$17.10	$12.65
92543	Caloric vestibular test		X	0660	1.4693	$101.20	$27.10	$20.24
92544	Optokinetic nystagmus test		X	0363	0.9181	$63.24	$17.10	$12.65
92545	Oscillating tracking test		X	0363	0.9181	$63.24	$17.10	$12.65
92546	Sinusoidal rotational test		X	0660	1.4693	$101.20	$27.10	$20.24
92547	Supplemental electrical test		N					
92548	Posturography		X	0660	1.4693	$101.20	$27.10	$20.24
92550	Tympanometry & reflex thresh		X	0364	0.4748	$32.70	$7.06	$6.54
92551	Pure tone hearing test air		E					
92552	Pure tone audiometry air		X	0364	0.4748	$32.70	$7.06	$6.54
92553	Audiometry air & bone		X	0365	1.2699	$87.47	$18.52	$17.50
92555	Speech threshold audiometry		X	0364	0.4748	$32.70	$7.06	$6.54
92556	Speech audiometry complete		X	0364	0.4748	$32.70	$7.06	$6.54
92557	Comprehensive hearing test		X	0365	1.2699	$87.47	$18.52	$17.50
92559	Group audiometric testing		E					
92560	Bekesy audiometry screen		E					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92561	Bekesy audiometry diagnosis		X	0364	0.4748	$32.70	$7.06	$6.54
92562	Loudness balance test		X	0364	0.4748	$32.70	$7.06	$6.54
92563	Tone decay hearing test		X	0364	0.4748	$32.70	$7.06	$6.54
92564	Sisi hearing test		X	0364	0.4748	$32.70	$7.06	$6.54
92565	Stenger test pure tone		X	0364	0.4748	$32.70	$7.06	$6.54
92567	Tympanometry		X	0364	0.4748	$32.70	$7.06	$6.54
92568	Acoustic refl threshold tst		X	0364	0.4748	$32.70	$7.06	$6.54
92570	Acoustic immitance testing		X	0364	0.4748	$32.70	$7.06	$6.54
92571	Filtered speech hearing test		X	0364	0.4748	$32.70	$7.06	$6.54
92572	Staggered spondaic word test		X	0366	1.8077	$124.51	$24.94	$24.91
92575	Sensorineural acuity test		X	0364	0.4748	$32.70	$7.06	$6.54
92576	Synthetic sentence test		X	0364	0.4748	$32.70	$7.06	$6.54
92577	Stenger test speech		X	0366	1.8077	$124.51	$24.94	$24.91
92579	Visual audiometry (vra)		X	0365	1.2699	$87.47	$18.52	$17.50
92582	Conditioning play audiometry		X	0365	1.2699	$87.47	$18.52	$17.50
92583	Select picture audiometry		X	0364	0.4748	$32.70	$7.06	$6.54
92584	Electrocochleography		S	0216	2.7030	$186.17	.	$37.24
92585	Auditor evoke potent compre		S	0216	2.7030	$186.17	.	$37.24
92586	Auditor evoke potent limit		S	0218	1.1728	$80.78	.	$16.16
92587	Evoked auditory test		X	0363	0.9181	$63.24	$17.10	$12.65
92588	Evoked auditory test		X	0363	0.9181	$63.24	$17.10	$12.65
92590	Hearing aid exam one ear		E					
92591	Hearing aid exam both ears		E					
92592	Hearing aid check one ear		E					
92593	Hearing aid check both ears		E					
92594	Electro hearng aid test one		E					
92595	Electro hearng aid tst both		E					
92596	Ear protector evaluation		X	0364	0.4748	$32.70	$7.06	$6.54
92597	Oral speech device eval		A					
92601	Cochlear implt f/up exam < 7		X	0366	1.8077	$124.51	$24.94	$24.91
92602	Reprogram cochlear implt < 7		X	0366	1.8077	$124.51	$24.94	$24.91
92603	Cochlear implt f/up exam 7 >		X	0366	1.8077	$124.51	$24.94	$24.91
92604	Reprogram cochlear implt 7 >		X	0366	1.8077	$124.51	$24.94	$24.91
92605	Eval for nonspeech device rx		A					
92606	Non-speech device service		A					
92607	Ex for speech device rx 1hr		A					
92608	Ex for speech device rx addl		A					
92609	Use of speech device service		A					
92610	Evaluate swallowing function		A					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92611	Motion fluoroscopy/swallow		A					
92612	Endoscopy swallow tst (fees)		A					
92613	Endoscopy swallow tst (fees)		B					
92614	Laryngoscopic sensory test		A					
92615	Eval laryngoscopy sense tst		E					
92616	Fees w/laryngeal sense test		A					
92617	Interprt fees/laryngeal test		E					
92620	Auditory function 60 min		X	0365	1.2699	$87.47	$18.52	$17.50
92621	Auditory function + 15 min		N					
92625	Tinnitus assessment		X	0365	1.2699	$87.47	$18.52	$17.50
92626	Eval aud rehab status		X	0366	1.8077	$124.51	$24.94	$24.91
92627	Eval aud status rehab add-on		N					
92630	Aud rehab pre-ling hear loss		E					
92633	Aud rehab postling hear loss		E					
92640	Aud brainstem implt programg		X	0365	1.2699	$87.47	$18.52	$17.50
92700	Ent procedure/service		X	0364	0.4748	$32.70	$7.06	$6.54
92950	Heart/lung resuscitation cpr		S	0094	2.3671	$163.04	$45.71	$32.61
92953	Temporary external pacing	CH	Q3	0094	2.3671	$163.04	$45.71	$32.61
92960	Cardioversion electric ext		S	0679	5.4006	$371.97	$95.30	$74.40
92961	Cardioversion electric int		S	0679	5.4006	$371.97	$95.30	$74.40
92970	Cardioassist internal		C					
92971	Cardioassist external		C					
92973	Percut coronary thrombectomy		T	0088	41.7208	$2,873.56	$655.22	$574.72
92974	Cath place cardio brachytx		T	0103	19.1361	$1,318.02	.	$263.61
92975	Dissolve clot heart vessel		C					
92977	Dissolve clot heart vessel		T	0676	2.3474	$161.68	.	$32.34
92978	Intravasc us heart add-on		N					
92979	Intravasc us heart add-on		N					
92980	Insert intracoronary stent		T	0104	82.1118	$5,655.53	.	$1,131.11
92981	Insert intracoronary stent		T	0104	82.1118	$5,655.53	.	$1,131.11
92982	Coronary artery dilation		T	0083	54.8838	$3,780.18	.	$756.04
92984	Coronary artery dilation		T	0083	54.8838	$3,780.18	.	$756.04
92986	Revision of aortic valve		T	0083	54.8838	$3,780.18	.	$756.04
92987	Revision of mitral valve		T	0083	54.8838	$3,780.18	.	$756.04
92990	Revision of pulmonary valve		T	0083	54.8838	$3,780.18	.	$756.04
92992	Revision of heart chamber		C					
92993	Revision of heart chamber		C					
92995	Coronary atherectomy		T	0082	92.7252	$6,386.54	.	$1,277.31
92996	Coronary atherectomy add-on		T	0082	92.7252	$6,386.54	.	$1,277.31

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92997	Pul art balloon repr percut		T	0083	54.8838	$3,780.18	.	$756.04
92998	Pul art balloon repr percut		T	0083	54.8838	$3,780.18	.	$756.04
93000	Electrocardiogram complete		M					
93005	Electrocardiogram tracing		S	0099	0.3958	$27.26	.	$5.46
93010	Electrocardiogram report		B					
93012	Transmission of ecg	CH	D					
93014	Report on transmitted ecg	CH	D					
93015	Cardiovascular stress test		B					
93016	Cardiovascular stress test		B					
93017	Cardiovascular stress test		X	0100	2.5904	$178.42	$41.44	$35.69
93018	Cardiovascular stress test		B					
93024	Cardiac drug stress test		X	0100	2.5904	$178.42	$41.44	$35.69
93025	Microvolt t-wave assess		X	0100	2.5904	$178.42	$41.44	$35.69
93040	Rhythm ECG with report		B					
93041	Rhythm ecg tracing		X	0035	0.2674	$18.42	.	$3.69
93042	Rhythm ecg report		B					
93224	Ecg monit/reprt up to 48 hrs		M					
93225	Ecg monit/reprt up to 48 hrs		S	0097	0.9619	$66.25	$23.79	$13.25
93226	Ecg monit/reprt up to 48 hrs		S	0097	0.9619	$66.25	$23.79	$13.25
93227	Ecg monit/reprt up to 48 hrs		M					
93228	Remote 30 day ecg rev/report		M					
93229	Remote 30 day ecg tech supp		S	0209	11.3359	$780.77	$268.73	$156.16
93230	ECG monitor/report, 24 hrs	CH	D					
93231	Ecg monitor/record, 24 hrs	CH	D					
93232	ECG monitor/report, 24 hrs	CH	D					
93233	ECG monitor/review, 24 hrs	CH	D					
93235	ECG monitor/report, 24 hrs	CH	D					
93236	ECG monitor/report, 24 hrs	CH	D					
93237	ECG monitor/review, 24 hrs	CH	D					
93268	ECG record/review		M					
93270	Remote 30 day ecg rev/report		S	0097	0.9619	$66.25	$23.79	$13.25
93271	Ecg/monitoring and analysis		S	0692	1.6109	$110.95	.	$22.19
93272	Ecg/review interpret only		M					
93278	ECG/signal-averaged		X	0035	0.2674	$18.42	.	$3.69
93279	Pm device progr eval sngl		S	0690	0.5093	$35.08	$8.67	$7.02
93280	Pm device progr eval dual		S	0690	0.5093	$35.08	$8.67	$7.02
93281	Pm device progr eval multi		S	0690	0.5093	$35.08	$8.67	$7.02
93282	Icd device prog eval 1 sngl	CH	S	0690	0.5093	$35.08	$8.67	$7.02
93283	Icd device progr eval dual	CH	S	0690	0.5093	$35.08	$8.67	$7.02

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93284	Icd device progr eval mult	CH	S	0690	0.5093	$35.08	$8.67	$7.02
93285	Ilr device eval progr		S	0690	0.5093	$35.08	$8.67	$7.02
93286	Pre-op pm device eval		N					
93287	Pre-op icd device eval		N					
93288	Pm device eval in person		S	0690	0.5093	$35.08	$8.67	$7.02
93289	Icd device interrogate	CH	S	0690	0.5093	$35.08	$8.67	$7.02
93290	Icm device eval	CH	X	0035	0.2674	$18.42	.	$3.69
93291	Ilr device interrogate		S	0690	0.5093	$35.08	$8.67	$7.02
93292	Wcd device interrogate	CH	S	0690	0.5093	$35.08	$8.67	$7.02
93293	Pm phone r-strip device eval	CH	S	0690	0.5093	$35.08	$8.67	$7.02
93294	Pm device interrogate remote		M					
93295	Icd device interrogat remote		M					
93296	Pm/icd remote tech serv	CH	S	0690	0.5093	$35.08	$8.67	$7.02
93297	Icm device interrogat remote		M					
93298	Ilr device interrogat remote		M					
93299	Icm/ilr remote tech serv	CH	S	0691	2.4221	$166.82	.	$33.37
93303	Echo transthoracic		S	0270	8.1617	$562.15	$133.61	$112.43
93304	Echo transthoracic		S	0269	5.8423	$402.39	.	$80.48
93306	Tte w/doppler complete		S	0269	5.8423	$402.39	.	$80.48
93307	Tte w/o doppler complete	CH	S	0269	5.8423	$402.39	.	$80.48
93308	Tte f-up or lmtd		S	0697	3.0827	$212.32	.	$42.47
93312	Echo transesophageal		S	0270	8.1617	$562.15	$133.61	$112.43
93313	Echo transesophageal		S	0269	5.8423	$402.39	.	$80.48
93314	Echo transesophageal		N					
93315	Echo transesophageal		S	0270	8.1617	$562.15	$133.61	$112.43
93316	Echo transesophageal		S	0270	8.1617	$562.15	$133.61	$112.43
93317	Echo transesophageal		N					
93318	Echo transesophageal intraop		S	0270	8.1617	$562.15	$133.61	$112.43
93320	Doppler echo exam heart		N					
93321	Doppler echo exam heart		N					
93325	Doppler color flow add-on		N					
93350	Stress tte only		S	0269	5.8423	$402.39	.	$80.48
93351	Stress tte complete		S	0270	8.1617	$562.15	$133.61	$112.43
93352	Admin ecg contrast agent		M					
93451	Right heart cath	NI	T	0080	39.5907	$2,726.85	$838.92	$545.37
93452	Left hrt cath w/ventrclgrphy	NI	T	0080	39.5907	$2,726.85	$838.92	$545.37
93453	R&l hrt cath w/ventriclgrphy	NI	T	0080	39.5907	$2,726.85	$838.92	$545.37
93454	Coronary artery angio s&i	NI	T	0080	39.5907	$2,726.85	$838.92	$545.37
93455	Coronary art/grft angio s&i	NI	T	0080	39.5907	$2,726.85	$838.92	$545.37

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93456	R hrt coronary artery angio	NI	T	0080	39.5907	$2,726.85	$838.92	$545.37
93457	R hrt art/grft angio	NI	T	0080	39.5907	$2,726.85	$838.92	$545.37
93458	L hrt artery/ventricle angio	NI	T	0080	39.5907	$2,726.85	$838.92	$545.37
93459	L hrt art/grft angio	NI	T	0080	39.5907	$2,726.85	$838.92	$545.37
93460	R&l hrt art/ventricle angio	NI	T	0080	39.5907	$2,726.85	$838.92	$545.37
93461	R&l hrt art/ventricle angio	NI	T	0080	39.5907	$2,726.85	$838.92	$545.37
93462	L hrt cath trnsptl puncture	NI	T	0080	39.5907	$2,726.85	$838.92	$545.37
93463	Drug admin & hemodynmic meas	NI	N					
93464	Exercise w/hemodynamic meas	NI	N					
93501	Right heart catheterization	CH	D					
93503	Insert/place heart catheter		T	0103	19.1361	$1,318.02	.	$263.61
93505	Biopsy of heart lining		T	0103	19.1361	$1,318.02	.	$263.61
93508	Cath placement, angiography	CH	D					
93510	Left heart catheterization	CH	D					
93511	Left heart catheterization	CH	D					
93514	Left heart catheterization	CH	D					
93524	Left heart catheterization	CH	D					
93526	Rt & Lt heart catheters	CH	D					
93527	Rt & Lt heart catheters	CH	D					
93528	Rt & Lt heart catheters	CH	D					
93529	Rt, lt heart catheterization	CH	D					
93530	Rt heart cath congenital		T	0080	39.5907	$2,726.85	$838.92	$545.37
93531	R & l heart cath congenital		T	0080	39.5907	$2,726.85	$838.92	$545.37
93532	R & l heart cath congenital		T	0080	39.5907	$2,726.85	$838.92	$545.37
93533	R & l heart cath congenital		T	0080	39.5907	$2,726.85	$838.92	$545.37
93539	Injection, cardiac cath	CH	D					
93540	Injection, cardiac cath	CH	D					
93541	Injection for lung angiogram	CH	D					
93542	Injection for heart x-rays	CH	D					
93543	Injection for heart x-rays	CH	D					
93544	Injection for aortography	CH	D					
93545	Inject for coronary x-rays	CH	D					
93555	Imaging, cardiac cath	CH	D					
93556	Imaging, cardiac cath	CH	D					
93561	Cardiac output measurement		N					
93562	Cardiac output measurement		N					
93563	Inject congenital card cath	NI	N					

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93564	Inject hrt congntl art/grft	NI	N					
93565	Inject l ventr/atrial angio	NI	N					
93566	Inject r ventr/atrial angio	NI	N					
93567	Inject suprvlv aortography	NI	N					
93568	Inject pulm art hrt cath	NI	N					
93571	Heart flow reserve measure		N					
93572	Heart flow reserve measure		N					
93580	Transcath closure of asd		T	0434	157.0167	$10,814.68	.	$2,162.94
93581	Transcath closure of vsd		T	0434	157.0167	$10,814.68	.	$2,162.94
93600	Bundle of His recording		S	0084	10.3020	$709.56	.	$141.92
93602	Intra-atrial recording		S	0084	10.3020	$709.56	.	$141.92
93603	Right ventricular recording		S	0084	10.3020	$709.56	.	$141.92
93609	Map tachycardia add-on		N					
93610	Intra-atrial pacing		S	0084	10.3020	$709.56	.	$141.92
93612	Intraventricular pacing		S	0084	10.3020	$709.56	.	$141.92
93613	Electrophys map 3d add-on		N					
93615	Esophageal recording		S	0084	10.3020	$709.56	.	$141.92
93616	Esophageal recording		S	0084	10.3020	$709.56	.	$141.92
93618	Heart rhythm pacing		S	0084	10.3020	$709.56	.	$141.92
93619	Electrophysiology evaluation		Q3	0085	53.6428	$3,694.70	.	$738.94
93620	Electrophysiology evaluation		Q3	0085	53.6428	$3,694.70	.	$738.94
93621	Electrophysiology evaluation		N					
93622	Electrophysiology evaluation		N					
93623	Stimulation pacing heart		N					
93624	Electrophysiologic study		T	0085	53.6428	$3,694.70	.	$738.94
93631	Heart pacing mapping		N					
93640	Evaluation heart device		N					
93641	Electrophysiology evaluation		N					
93642	Electrophysiology evaluation		S	0084	10.3020	$709.56	.	$141.92
93650	Ablate heart dysrhythm focus		Q3	0085	53.6428	$3,694.70	.	$738.94
93651	Ablate heart dysrhythm focus		Q3	0086	122.6468	$8,447.42	.	$1,689.49
93652	Ablate heart dysrhythm focus		Q3	0086	122.6468	$8,447.42	.	$1,689.49
93660	Tilt table evaluation		S	0101	4.2671	$293.90	$100.24	$58.78
93662	Intracardiac ecg (ice)		N					
93668	Peripheral vascular rehab		E					
93701	Bioimpedance cv analysis		S	0099	0.3958	$27.26	.	$5.46
93720	Total body plethysmography		B					
93721	Plethysmography tracing		X	0368	0.8657	$59.63	$20.93	$11.93
93722	Plethysmography report		B					

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93724	Analyze pacemaker system		S	0690	0.5093	$35.08	$8.67	$7.02
93740	Temperature gradient studies		X	0368	0.8657	$59.63	$20.93	$11.93
93745	Set-up cardiovert-defibrill	CH	S	0690	0.5093	$35.08	$8.67	$7.02
93750	Interrogation vad in person		S	0692	1.6109	$110.95	.	$22.19
93770	Measure venous pressure		N					
93784	Ambulatory BP monitoring		E					
93786	Ambulatory BP recording		S	0097	0.9619	$66.25	$23.79	$13.25
93788	Ambulatory BP analysis		S	0097	0.9619	$66.25	$23.79	$13.25
93790	Review/report BP recording		M					
93797	Cardiac rehab		S	0095	0.9991	$68.81	$13.86	$13.77
93798	Cardiac rehab/monitor		S	0095	0.9991	$68.81	$13.86	$13.77
93799	Cardiovascular procedure		S	0097	0.9619	$66.25	$23.79	$13.25
93875	Extracranial study		S	0096	1.5460	$106.48	$36.86	$21.30
93880	Extracranial study		S	0267	2.2212	$152.99	$59.84	$30.60
93882	Extracranial study		S	0267	2.2212	$152.99	$59.84	$30.60
93886	Intracranial study		S	0267	2.2212	$152.99	$59.84	$30.60
93888	Intracranial study		S	0265	0.9038	$62.25	$22.26	$12.45
93890	Tcd vasoreactivity study		S	0266	1.3979	$96.28	$37.23	$19.26
93892	Tcd emboli detect w/o inj		S	0266	1.3979	$96.28	$37.23	$19.26
93893	Tcd emboli detect w/inj		S	0266	1.3979	$96.28	$37.23	$19.26
93922	Upr/l xtremity art 2 levels		S	0097	0.9619	$66.25	$23.79	$13.25
93923	Upr/lxtr art stdy 3+ lvls		S	0096	1.5460	$106.48	$36.86	$21.30
93924	Lwr xtr vasc stdy bilat		S	0096	1.5460	$106.48	$36.86	$21.30
93925	Lower extremity study		S	0267	2.2212	$152.99	$59.84	$30.60
93926	Lower extremity study		S	0266	1.3979	$96.28	$37.23	$19.26
93930	Upper extremity study		S	0267	2.2212	$152.99	$59.84	$30.60
93931	Upper extremity study		S	0266	1.3979	$96.28	$37.23	$19.26
93965	Extremity study		S	0096	1.5460	$106.48	$36.86	$21.30
93970	Extremity study		S	0267	2.2212	$152.99	$59.84	$30.60
93971	Extremity study		S	0266	1.3979	$96.28	$37.23	$19.26
93975	Vascular study		S	0267	2.2212	$152.99	$59.84	$30.60
93976	Vascular study		S	0267	2.2212	$152.99	$59.84	$30.60
93978	Vascular study		S	0267	2.2212	$152.99	$59.84	$30.60
93979	Vascular study		S	0266	1.3979	$96.28	$37.23	$19.26
93980	Penile vascular study		S	0267	2.2212	$152.99	$59.84	$30.60
93981	Penile vascular study		S	0267	2.2212	$152.99	$59.84	$30.60
93982	Aneurysm pressure sens study		S	0097	0.9619	$66.25	$23.79	$13.25
93990	Doppler flow testing		S	0266	1.3979	$96.28	$37.23	$19.26
94002	Vent mgmt inpat init day	CH	Q3	0079	2.9048	$200.07	.	$40.02

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94003	Vent mgmt inpat subq day	CH	Q3	0079	2.9048	$200.07	.	$40.02
94004	Vent mgmt nf per day		B					
94005	Home vent mgmt supervision		M					
94010	Breathing capacity test		X	0368	0.8657	$59.63	$20.93	$11.93
94011	Spirometry up to 2 yrs old		X	0368	0.8657	$59.63	$20.93	$11.93
94012	Spirmtry w/bmchdil inf-2 yr		X	0368	0.8657	$59.63	$20.93	$11.93
94013	Meas lung vol thru 2 yrs		X	0369	3.0144	$207.62	$42.19	$41.53
94014	Patient recorded spirometry		X	0367	0.5892	$40.58	$13.76	$8.12
94015	Patient recorded spirometry		X	0367	0.5892	$40.58	$13.76	$8.12
94016	Review patient spirometry		A					
94060	Evaluation of wheezing		S	0078	1.4318	$98.62	.	$19.73
94070	Evaluation of wheezing		X	0369	3.0144	$207.62	$42.19	$41.53
94150	Vital capacity test		X	0367	0.5892	$40.58	$13.76	$8.12
94200	Lung function test (MBC/MVV)		X	0367	0.5892	$40.58	$13.76	$8.12
94240	Residual lung capacity		X	0368	0.8657	$59.63	$20.93	$11.93
94250	Expired gas collection	CH	X	0367	0.5892	$40.58	$13.76	$8.12
94260	Thoracic gas volume		X	0368	0.8657	$59.63	$20.93	$11.93
94350	Lung nitrogen washout curve		X	0368	0.8657	$59.63	$20.93	$11.93
94360	Measure airflow resistance		X	0367	0.5892	$40.58	$13.76	$8.12
94370	Breath airway closing volume		X	0035	0.2674	$18.42	.	$3.69
94375	Respiratory flow volume loop		X	0368	0.8657	$59.63	$20.93	$11.93
94400	CO2 breathing response curve		X	0367	0.5892	$40.58	$13.76	$8.12
94450	Hypoxia response curve		X	0368	0.8657	$59.63	$20.93	$11.93
94452	Hast w/report		X	0368	0.8657	$59.63	$20.93	$11.93
94453	Hast w/oxygen titrate		X	0368	0.8657	$59.63	$20.93	$11.93
94610	Surfactant admin thru tube		S	0077	0.4171	$28.73	$7.74	$5.75
94620	Pulmonary stress test/simple		X	0368	0.8657	$59.63	$20.93	$11.93
94621	Pulm stress test/complex		X	0369	3.0144	$207.62	$42.19	$41.53
94640	Airway inhalation treatment		S	0077	0.4171	$28.73	$7.74	$5.75
94642	Aerosol inhalation treatment		S	0078	1.4318	$98.62	.	$19.73
94644	Cbt 1st hour		X	0340	0.6712	$46.23	.	$9.25
94645	Cbt each addl hour		X	0340	0.6712	$46.23	.	$9.25
94660	Pos airway pressure cpap	CH	Q3	0078	1.4318	$98.62	.	$19.73
94662	Neg press ventilation cnp	CH	Q3	0079	2.9048	$200.07	.	$40.02
94664	Evaluate pt use of inhaler		S	0077	0.4171	$28.73	$7.74	$5.75
94667	Chest wall manipulation		S	0077	0.4171	$28.73	$7.74	$5.75
94668	Chest wall manipulation		S	0077	0.4171	$28.73	$7.74	$5.75
94680	Exhaled air analysis o2	CH	X	0368	0.8657	$59.63	$20.93	$11.93
94681	Exhaled air analysis o2/co2		X	0368	0.8657	$59.63	$20.93	$11.93

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94690	Exhaled air analysis		X	0367	0.5892	$40.58	$13.76	$8.12
94720	Monoxide diffusing capacity		X	0368	0.8657	$59.63	$20.93	$11.93
94725	Membrane diffusion capacity		X	0368	0.8657	$59.63	$20.93	$11.93
94750	Pulmonary compliance study		X	0367	0.5892	$40.58	$13.76	$8.12
94760	Measure blood oxygen level		N					
94761	Measure blood oxygen level		N					
94762	Measure blood oxygen level	CH	Q3	0097	0.9619	$66.25	$23.79	$13.25
94770	Exhaled carbon dioxide test	CH	X	0368	0.8657	$59.63	$20.93	$11.93
94772	Breath recording infant		X	0369	3.0144	$207.62	$42.19	$41.53
94774	Ped home apnea rec compl		B					
94775	Ped home apnea rec hk-up		S	0097	0.9619	$66.25	$23.79	$13.25
94776	Ped home apnea rec downld		S	0097	0.9619	$66.25	$23.79	$13.25
94777	Ped home apnea rec report		B					
94799	Pulmonary service/procedure		X	0367	0.5892	$40.58	$13.76	$8.12
95004	Percut allergy skin tests		X	0381	0.4819	$33.19	.	$6.64
95010	Percut allergy titrate test		X	0381	0.4819	$33.19	.	$6.64
95012	Exhaled nitric oxide meas		X	0367	0.5892	$40.58	$13.76	$8.12
95015	Id allergy titrate-drug/bug		X	0381	0.4819	$33.19	.	$6.64
95024	Id allergy test drug/bug		X	0381	0.4819	$33.19	.	$6.64
95027	Id allergy titrate-airborne		X	0381	0.4819	$33.19	.	$6.64
95028	Id allergy test-delayed type		X	0381	0.4819	$33.19	.	$6.64
95044	Allergy patch tests		X	0381	0.4819	$33.19	.	$6.64
95052	Photo patch test		X	0381	0.4819	$33.19	.	$6.64
95056	Photosensitivity tests		X	0370	1.3134	$90.46	.	$18.10
95060	Eye allergy tests		X	0370	1.3134	$90.46	.	$18.10
95065	Nose allergy test		X	0381	0.4819	$33.19	.	$6.64
95070	Bronchial allergy tests		X	0369	3.0144	$207.62	$42.19	$41.53
95071	Bronchial allergy tests		X	0369	3.0144	$207.62	$42.19	$41.53
95075	Ingestion challenge test		X	0361	4.1013	$282.48	$83.23	$56.50
95115	Immunotherapy one injection		S	0436	0.3826	$26.35	.	$5.27
95117	Immunotherapy injections		S	0436	0.3826	$26.35	.	$5.27
95120	Immunotherapy one injection		E					
95125	Immunotherapy many antigens		E					
95130	Immunotherapy insect venom		E					
95131	Immunotherapy insect venoms		E					
95132	Immunotherapy insect venoms		E					
95133	Immunotherapy insect venoms		E					
95134	Immunotherapy insect venoms		E					
95144	Antigen therapy services		S	0437	0.5354	$36.88	.	$7.38

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95145	Antigen therapy services		S	0437	0.5354	$36.88	.	$7.38
95146	Antigen therapy services		S	0438	1.0974	$75.58	.	$15.12
95147	Antigen therapy services		S	0438	1.0974	$75.58	.	$15.12
95148	Antigen therapy services		S	0437	0.5354	$36.88	.	$7.38
95149	Antigen therapy services		S	0437	0.5354	$36.88	.	$7.38
95165	Antigen therapy services		S	0436	0.3826	$26.35	.	$5.27
95170	Antigen therapy services		S	0437	0.5354	$36.88	.	$7.38
95180	Rapid desensitization		X	0370	1.3134	$90.46	.	$18.10
95199	Allergy immunology services		X	0381	0.4819	$33.19	.	$6.64
95250	Glucose monitoring cont		V	0607	1.8654	$128.48	.	$25.70
95251	Gluc monitor cont phys i&r		B					
95800	Slp stdy unattended	NI	S	0213	2.4194	$166.64	$53.58	$33.33
95801	Slp stdy unatnd w/anal	NI	S	0213	2.4194	$166.64	$53.58	$33.33
95803	Actigraphy testing		S	0218	1.1728	$80.78	.	$16.16
95805	Multiple sleep latency test		S	0209	11.3359	$780.77	$268.73	$156.16
95806	Sleep study unatt&resp efft		S	0213	2.4194	$166.64	$53.58	$33.33
95807	Sleep study attended		S	0209	11.3359	$780.77	$268.73	$156.16
95808	Polysomnography 1-3		S	0209	11.3359	$780.77	$268.73	$156.16
95810	Polysomnography 4 or more		S	0209	11.3359	$780.77	$268.73	$156.16
95811	Polysomnography w/cpap		S	0209	11.3359	$780.77	$268.73	$156.16
95812	Eeg 41-60 minutes		S	0213	2.4194	$166.64	$53.58	$33.33
95813	Eeg over 1 hour		S	0213	2.4194	$166.64	$53.58	$33.33
95816	Eeg awake and drowsy		S	0213	2.4194	$166.64	$53.58	$33.33
95819	Eeg awake and asleep		S	0213	2.4194	$166.64	$53.58	$33.33
95822	Eeg coma or sleep only		S	0213	2.4194	$166.64	$53.58	$33.33
95824	Eeg cerebral death only		S	0216	2.7030	$186.17	.	$37.24
95827	Eeg all night recording		S	0213	2.4194	$166.64	$53.58	$33.33
95829	Surgery electrocorticogram		N					
95830	Insert electrodes for EEG		B					
95831	Limb muscle testing manual		A					
95832	Hand muscle testing manual		A					
95833	Body muscle testing manual		A					
95834	Body muscle testing manual		A					
95851	Range of motion measurements		A					
95852	Range of motion measurements		A					
95857	Cholinesterase challenge		S	0218	1.1728	$80.78	.	$16.16
95860	Muscle test one limb		S	0218	1.1728	$80.78	.	$16.16

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95861	Muscle test 2 limbs		S	0218	1.1728	$80.78	.	$16.16
95863	Muscle test 3 limbs		S	0218	1.1728	$80.78	.	$16.16
95864	Muscle test 4 limbs		S	0218	1.1728	$80.78	.	$16.16
95865	Muscle test larynx		S	0218	1.1728	$80.78	.	$16.16
95866	Muscle test hemidiaphragm		S	0218	1.1728	$80.78	.	$16.16
95867	Muscle test cran nerv unilat		S	0218	1.1728	$80.78	.	$16.16
95868	Muscle test cran nerve bilat		S	0218	1.1728	$80.78	.	$16.16
95869	Muscle test thor paraspinal		S	0215	0.6518	$44.89	.	$8.98
95870	Muscle test nonparaspinal		S	0215	0.6518	$44.89	.	$8.98
95872	Muscle test one fiber		S	0218	1.1728	$80.78	.	$16.16
95873	Guide nerv destr elec stim		N					
95874	Guide nerv destr needle emg		N					
95875	Limb exercise test	CH	S	0218	1.1728	$80.78	.	$16.16
95900	Motor nerve conduction test		S	0215	0.6518	$44.89	.	$8.98
95903	Motor nerve conduction test		S	0215	0.6518	$44.89	.	$8.98
95904	Sense nerve conduction test		S	0215	0.6518	$44.89	.	$8.98
95905	Motor/sens nrve conduct test		S	0215	0.6518	$44.89	.	$8.98
95920	Intraop nerve test add-on		N					
95921	Autonomic nerv function test		S	0218	1.1728	$80.78	.	$16.16
95922	Autonomic nerv function test	CH	S	0218	1.1728	$80.78	.	$16.16
95923	Autonomic nerv function test		S	0218	1.1728	$80.78	.	$16.16
95925	Somatosensory testing		S	0216	2.7030	$186.17	.	$37.24
95926	Somatosensory testing		S	0216	2.7030	$186.17	.	$37.24
95927	Somatosensory testing		S	0216	2.7030	$186.17	.	$37.24
95928	C motor evoked uppr limbs		S	0218	1.1728	$80.78	.	$16.16
95929	C motor evoked lwr limbs		S	0218	1.1728	$80.78	.	$16.16
95930	Visual evoked potential test		S	0216	2.7030	$186.17	.	$37.24
95933	Blink reflex test		S	0215	0.6518	$44.89	.	$8.98
95934	H-reflex test		S	0215	0.6518	$44.89	.	$8.98
95936	H-reflex test		S	0215	0.6518	$44.89	.	$8.98
95937	Neuromuscular junction test		S	0218	1.1728	$80.78	.	$16.16
95950	Ambulatory eeg monitoring		S	0209	11.3359	$780.77	$268.73	$156.16
95951	EEG monitoring/videorecord		S	0209	11.3359	$780.77	$268.73	$156.16
95953	EEG monitoring/computer		S	0209	11.3359	$780.77	$268.73	$156.16
95954	EEG monitoring/giving drugs		S	0218	1.1728	$80.78	.	$16.16
95955	EEG during surgery		N					
95956	Eeg monitor technol attended		S	0209	11.3359	$780.77	$268.73	$156.16
95957	EEG digital analysis		N					
95958	EEG monitoring/function test		S	0213	2.4194	$166.64	$53.58	$33.33

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95961	Electrode stimulation brain		S	0216	2.7030	$186.17	.	$37.24
95962	Electrode stim brain add-on		S	0216	2.7030	$186.17	.	$37.24
95965	Meg spontaneous		S	0067	49.4903	$3,408.69	.	$681.74
95966	Meg evoked single		S	0065	14.1866	$977.12	.	$195.43
95967	Meg evoked each addl		S	0065	14.1866	$977.12	.	$195.43
95970	Analyze neurostim no prog		S	0218	1.1728	$80.78	.	$16.16
95971	Analyze neurostim simple		S	0692	1.6109	$110.95	.	$22.19
95972	Analyze neurostim complex		S	0692	1.6109	$110.95	.	$22.19
95973	Analyze neurostim complex		S	0692	1.6109	$110.95	.	$22.19
95974	Cranial neurostim complex		S	0692	1.6109	$110.95	.	$22.19
95975	Cranial neurostim complex		S	0692	1.6109	$110.95	.	$22.19
95978	Analyze neurostim brain/1h		S	0692	1.6109	$110.95	.	$22.19
95979	Analyz neurostim brain addon		S	0692	1.6109	$110.95	.	$22.19
95980	Io anal gast n-stim init		N					
95981	Io anal gast n-stim subsq		S	0218	1.1728	$80.78	.	$16.16
95982	Io ga n-stim subsq w/reprog		S	0692	1.6109	$110.95	.	$22.19
95990	Spin/brain pump refil & main		S	0439	1.8648	$128.44	.	$25.69
95991	Spin/brain pump refil & main		S	0439	1.8648	$128.44	.	$25.69
95992	Canalith repositioning proc	CH	A					
95999	Neurological procedure		S	0215	0.6518	$44.89	.	$8.98
96000	Motion analysis video/3d		S	0216	2.7030	$186.17	.	$37.24
96001	Motion test w/ft press meas		S	0216	2.7030	$186.17	.	$37.24
96002	Dynamic surface emg		S	0218	1.1728	$80.78	.	$16.16
96003	Dynamic fine wire emg	CH	S	0218	1.1728	$80.78	.	$16.16
96004	Phys review of motion tests		B					
96020	Functional brain mapping		N					
96040	Genetic counseling 30 min		B					
96101	Psycho testing by psych/phys		Q3	0382	2.6972	$185.77	.	$37.16
96102	Psycho testing by technician		Q3	0382	2.6972	$185.77	.	$37.16
96103	Psycho testing admin by comp		Q3	0373	1.3342	$91.89	.	$18.38
96105	Assessment of aphasia		A					
96110	Developmental test lim		Q3	0373	1.3342	$91.89	.	$18.38
96111	Developmental test extend		Q3	0373	1.3342	$91.89	.	$18.38
96116	Neurobehavioral status exam		Q3	0382	2.6972	$185.77	.	$37.16
96118	Neuropsych tst by psych/phys		Q3	0382	2.6972	$185.77	.	$37.16
96119	Neuropsych testing by tec		Q3	0382	2.6972	$185.77	.	$37.16
96120	Neuropsych tst admin w/comp		Q3	0382	2.6972	$185.77	.	$37.16
96125	Cognitive test by hc pro		A					
96150	Assess hlth/behave init		Q3	0432	0.4795	$33.03	.	$6.61

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96151	Assess hlth/behave subseq		Q3	0432	0.4795	$33.03	.	$6.61
96152	Intervene hlth/behave indiv		Q3	0432	0.4795	$33.03	.	$6.61
96153	Intervene hlth/behave group		Q3	0432	0.4795	$33.03	.	$6.61
96154	Interv hlth/behav fam w/pt		Q3	0432	0.4795	$33.03	.	$6.61
96155	Interv hlth/behav fam no pt		E					
96360	Hydration iv infusion init		S	0438	1.0974	$75.58	.	$15.12
96361	Hydrate iv infusion add-on		S	0436	0.3826	$26.35	.	$5.27
96365	Ther/proph/diag iv inf init		S	0439	1.8648	$128.44	.	$25.69
96366	Ther/proph/diag iv inf addon		S	0436	0.3826	$26.35	.	$5.27
96367	Tx/proph/dg addl seq iv inf		S	0437	0.5354	$36.88	.	$7.38
96368	Ther/diag concurrent inf		N					
96369	Sc ther infusion up to 1 hr		S	0439	1.8648	$128.44	.	$25.69
96370	Sc ther infusion addl hr		S	0437	0.5354	$36.88	.	$7.38
96371	Sc ther infusion reset pump		S	0436	0.3826	$26.35	.	$5.27
96372	Ther/proph/diag inj sc/im		S	0436	0.3826	$26.35	.	$5.27
96373	Ther/proph/diag inj ia		S	0437	0.5354	$36.88	.	$7.38
96374	Ther/proph/diag inj iv push		S	0437	0.5354	$36.88	.	$7.38
96375	Tx/pro/dx inj new drug addon		S	0437	0.5354	$36.88	.	$7.38
96376	Tx/pro/dx inj same drug adon		N					
96379	Ther/prop/diag inj/inf proc		S	0436	0.3826	$26.35	.	$5.27
96401	Chemo anti-neopl sq/im		S	0437	0.5354	$36.88	.	$7.38
96402	Chemo hormon antineopl sq/im		S	0437	0.5354	$36.88	.	$7.38
96405	Chemo intralesional up to 7		S	0437	0.5354	$36.88	.	$7.38
96406	Chemo intralesional over 7		S	0439	1.8648	$128.44	.	$25.69
96409	Chemo iv push sngl drug		S	0439	1.8648	$128.44	.	$25.69
96411	Chemo iv push addl drug		S	0438	1.0974	$75.58	.	$15.12
96413	Chemo iv infusion 1 hr		S	0440	2.9888	$205.86	.	$41.18
96415	Chemo iv infusion addl hr		S	0437	0.5354	$36.88	.	$7.38
96416	Chemo prolong infuse w/pump		S	0440	2.9888	$205.86	.	$41.18
96417	Chemo iv infus each addl seq		S	0438	1.0974	$75.58	.	$15.12
96420	Chemo ia push tecnique		S	0438	1.0974	$75.58	.	$15.12
96422	Chemo ia infusion up to 1 hr		S	0440	2.9888	$205.86	.	$41.18
96423	Chemo ia infuse each addl hr		S	0438	1.0974	$75.58	.	$15.12
96425	Chemotherapy infusion method		S	0440	2.9888	$205.86	.	$41.18
96440	Chemotherapy intracavitary		S	0439	1.8648	$128.44	.	$25.69
96445	Chemotherapy, intracavitary	CH	D					
96446	Chemotx admn prtl cavity	NI	S	0439	1.8648	$128.44	.	$25.69
96450	Chemotherapy into cns		S	0440	2.9888	$205.86	.	$41.18
96521	Refill/maint portable pump		S	0439	1.8648	$128.44	.	$25.69

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96522	Refill/maint pump/resvr syst		S	0439	1.8648	$128.44	.	$25.69
96523	Irrig drug delivery device		Q1	0624	0.6328	$43.58	$12.65	$8.72
96542	Chemotherapy injection		S	0438	1.0974	$75.58	.	$15.12
96549	Chemotherapy unspecified		S	0436	0.3826	$26.35	.	$5.27
96567	Photodynamic tx skin	CH	T	0015	1.4975	$103.14	.	$20.63
96570	Photodynmc tx 30 min add-on		T	0015	1.4975	$103.14	.	$20.63
96571	Photodynamic tx addl 15 min		T	0015	1.4975	$103.14	.	$20.63
96900	Ultraviolet light therapy		S	0001	0.5543	$38.18	.	$7.64
96902	Trichogram		N					
96904	Whole body photography		N					
96910	Photochemotherapy with UV-B		S	0001	0.5543	$38.18	.	$7.64
96912	Photochemotherapy with UV-A		S	0001	0.5543	$38.18	.	$7.64
96913	Photochemotherapy uv-a or b		S	0683	2.9132	$200.65	.	$40.13
96920	Laser tx skin < 250 sq cm		T	0015	1.4975	$103.14	.	$20.63
96921	Laser tx skin 250-500 sq cm		T	0015	1.4975	$103.14	.	$20.63
96922	Laser tx skin > 500 sq cm		T	0015	1.4975	$103.14	.	$20.63
96999	Dermatological procedure		T	0012	0.4326	$29.80	.	$5.96
97001	Pt evaluation		A					
97002	Pt re-evaluation		A					
97003	Ot evaluation		A					
97004	Ot re-evaluation		A					
97005	Athletic train eval		E					
97006	Athletic train reeval		E					
97010	Hot or cold packs therapy		A					
97012	Mechanical traction therapy		A					
97014	Electric stimulation therapy		E					
97016	Vasopneumatic device therapy		A					
97018	Paraffin bath therapy		A					
97022	Whirlpool therapy		A					
97024	Diathermy eg microwave		A					
97026	Infrared therapy		A					
97028	Ultraviolet therapy		A					
97032	Electrical stimulation		A					
97033	Electric current therapy		A					
97034	Contrast bath therapy		A					
97035	Ultrasound therapy		A					
97036	Hydrotherapy		A					
97039	Physical therapy treatment		A					
97110	Therapeutic exercises		A					

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97112	Neuromuscular reeducation		A					
97113	Aquatic therapy/exercises		A					
97116	Gait training therapy		A					
97124	Massage therapy		A					
97139	Physical medicine procedure		A					
97140	Manual therapy		A					
97150	Group therapeutic procedures		A					
97530	Therapeutic activities		A					
97532	Cognitive skills development		A					
97533	Sensory integration		A					
97535	Self care mngment training		A					
97537	Community/work reintegration		A					
97542	Wheelchair mngment training		A					
97545	Work hardening		A					
97546	Work hardening add-on		A					
97597	Rmvl devital tis 20 cm/<		T	0015	1.4975	$103.14	.	$20.63
97598	Rmvl devital tis addl 20 cm<		T	0015	1.4975	$103.14	.	$20.63
97602	Wound(s) care non-selective		T	0013	0.9103	$62.70	.	$12.54
97605	Neg press wound tx < 50 cm		T	0013	0.9103	$62.70	.	$12.54
97606	Neg press wound tx > 50 cm		T	0015	1.4975	$103.14	.	$20.63
97750	Physical performance test		A					
97755	Assistive technology assess		A					
97760	Orthotic mgmt and training		A					
97761	Prosthetic training		A					
97762	C/o for orthotic/prosth use		A					
97799	Physical medicine procedure		A					
97802	Medical nutrition indiv in		A					
97803	Med nutrition indiv subseq		A					
97804	Medical nutrition group		A					
97810	Acupunct w/o stimul 15 min		E					
97811	Acupunct w/o stimul addl 15m		E					
97813	Acupunct w/stimul 15 min		E					
97814	Acupunct w/stimul addl 15m		E					
98925	Osteopathic manipulation		S	0060	0.2864	$19.73	.	$3.95
98926	Osteopathic manipulation		S	0060	0.2864	$19.73	.	$3.95
98927	Osteopathic manipulation		S	0060	0.2864	$19.73	.	$3.95
98928	Osteopathic manipulation		S	0060	0.2864	$19.73	.	$3.95
98929	Osteopathic manipulation		S	0060	0.2864	$19.73	.	$3.95
98940	Chiropractic manipulation		S	0060	0.2864	$19.73	.	$3.95

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
98941	Chiropractic manipulation		S	0060	0.2864	$19.73	.	$3.95
98942	Chiropractic manipulation		S	0060	0.2864	$19.73	.	$3.95
98943	Chiropractic manipulation		E					
98960	Self-mgmt educ & train 1 pt		E					
98961	Self-mgmt educ/train 2-4 pt		E					
98962	Self-mgmt educ/train 5-8 pt		E					
98966	Hc pro phone call 5-10 min		E					
98967	Hc pro phone call 11-20 min		E					
98968	Hc pro phone call 21-30 min		E					
98969	Online service by hc pro		E					
99000	Specimen handling		E					
99001	Specimen handling		E					
99002	Device handling		B					
99024	Postop follow-up visit		B					
99026	In-hospital on call service		E					
99027	Out-of-hosp on call service		E					
99050	Medical services after hrs		B					
99051	Med serv eve/wkend/holiday		B					
99053	Med serv 10pm-8am 24 hr fac		B					
99056	Med service out of office		B					
99058	Office emergency care		B					
99060	Out of office emerg med serv		B					
99070	Special supplies		B					
99071	Patient education materials		B					
99075	Medical testimony		E					
99078	Group health education		N					
99080	Special reports or forms		B					
99082	Unusual physician travel		B					
99090	Computer data analysis		B					
99091	Collect/review data from pt		N					
99100	Special anesthesia service		B					
99116	Anesthesia with hypothermia		B					
99135	Special anesthesia procedure		B					
99140	Emergency anesthesia		B					
99143	Mod cs by same phys < 5 yrs		N					
99144	Mod cs by same phys 5 yrs +		N					
99145	Mod cs by same phys add-on		N					
99148	Mod cs diff phys < 5 yrs		N					
99149	Mod cs diff phys 5 yrs +		N					

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99150	Mod cs diff phys add-on		N					
99170	Anogenital exam child		T	0191	0.1446	$9.96	$2.08	$2.00
99172	Ocular function screen		E					
99173	Visual acuity screen		E					
99174	Ocular photoscreening		E					
99175	Induction of vomiting		N					
99183	Hyperbaric oxygen therapy		B					
99190	Special pump services		C					
99191	Special pump services		C					
99192	Special pump services		C					
99195	Phlebotomy		X	0624	0.6328	$43.58	$12.65	$8.72
99199	Special service/proc/report		B					
99201	Office/outpatient visit new		V	0604	0.7602	$52.36	.	$10.48
99202	Office/outpatient visit new		V	0605	1.0908	$75.13	.	$15.03
99203	Office/outpatient visit new		V	0606	1.4477	$99.71	.	$19.95
99204	Office/outpatient visit new		V	0607	1.8654	$128.48	.	$25.70
99205	Office/outpatient visit new		Q3	0608	2.4525	$168.92	.	$33.79
99211	Office/outpatient visit est		V	0604	0.7602	$52.36	.	$10.48
99212	Office/outpatient visit est		V	0605	1.0908	$75.13	.	$15.03
99213	Office/outpatient visit est		V	0605	1.0908	$75.13	.	$15.03
99214	Office/outpatient visit est		V	0606	1.4477	$99.71	.	$19.95
99215	Office/outpatient visit est		Q3	0607	1.8654	$128.48	.	$25.70
99217	Observation care discharge		B					
99218	Initial observation caree		B					
99219	Initial observation care		B					
99220	Initial observation care		B					
99221	Initial hospital care		B					
99222	Initial hospital care		B					
99223	Initial hospital care		B					
99224	Subsequent observation care	NI	B					
99225	Subsequent observation care	NI	B					
99226	Subsequent observation care	NI	B					
99231	Subsequent hospital care		B					
99232	Subsequent hospital care		B					
99233	Subsequent hospital care		B					
99234	Observ/hosp same date		B					
99235	Observ/hosp same date		B					
99236	Observ/hosp same date		B					
99238	Hospital discharge day		B					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99239	Hospital discharge day		B					
99241	Office consultation		E					
99242	Office consultation		E					
99243	Office consultation		E					
99244	Office consultation		E					
99245	Office consultation		E					
99251	Inpatient consultation		E					
99252	Inpatient consultation		E					
99253	Inpatient consultation		E					
99254	Inpatient consultation		E					
99255	Inpatient consultation		E					
99281	Emergency dept visit		V	0609	0.7516	$51.77	$12.40	$10.36
99282	Emergency dept visit		V	0613	1.2667	$87.25	$20.97	$17.45
99283	Emergency dept visit		V	0614	2.0201	$139.14	$34.33	$27.83
99284	Emergency dept visit		Q3	0615	3.2316	$222.58	$48.48	$44.52
99285	Emergency dept visit		Q3	0616	4.7846	$329.54	$72.86	$65.91
99288	Direct advanced life support		B					
99291	Critical care first hour		Q3	0617	6.7477	$464.75	$104.95	$92.95
99292	Critical care addl 30 min		N					
99304	Nursing facility care init		B					
99305	Nursing facility care init		B					
99306	Nursing facility care init		B					
99307	Nursing fac care subseq		B					
99308	Nursing fac care subseq		B					
99309	Nursing fac care subseq		B					
99310	Nursing fac care subseq		B					
99315	Nursing fac discharge day		B					
99316	Nursing fac discharge day		B					
99318	Annual nursing fac assessmnt		B					
99324	Domicil/r-home visit new pat		B					
99325	Domicil/r-home visit new pat		B					
99326	Domicil/r-home visit new pat		B					
99327	Domicil/r-home visit new pat		B					
99328	Domicil/r-home visit new pat		B					
99334	Domicil/r-home visit est pat		B					
99335	Domicil/r-home visit est pat		B					
99336	Domicil/r-home visit est pat		B					
99337	Domicil/r-home visit est pat		B					
99339	Domicil/r-home care supervis		B					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99340	Domicil/r-home care supervis		B					
99341	Home visit new patient		B					
99342	Home visit new patient		B					
99343	Home visit new patient		B					
99344	Home visit new patient		B					
99345	Home visit new patient		B					
99347	Home visit est patient		B					
99348	Home visit est patient		B					
99349	Home visit est patient		B					
99350	Home visit est patient		B					
99354	Prolonged service office		N					
99355	Prolonged service office		N					
99356	Prolonged service inpatient		C					
99357	Prolonged service inpatient		C					
99358	Prolong service w/o contact		N					
99359	Prolong serv w/o contact add		N					
99360	Physician standby services		B					
99363	Anticoag mgmt init		B					
99364	Anticoag mgmt subseq		B					
99366	Team conf w/pat by hc pro		N					
99367	Team conf w/o pat by phys		N					
99368	Team conf w/o pat by hc pro		N					
99374	Home health care supervision		B					
99375	Home health care supervision		E					
99377	Hospice care supervision		B					
99378	Hospice care supervision		E					
99379	Nursing fac care supervision		B					
99380	Nursing fac care supervision		B					
99381	Init pm e/m new pat inf		E					
99382	Init pm e/m new pat 1-4 yrs		E					
99383	Prev visit new age 5-11		E					
99384	Prev visit new age 12-17		E					
99385	Prev visit new age 18-39		E					
99386	Prev visit new age 40-64		E					
99387	Init pm e/m new pat 65+ yrs		E					
99391	Per pm reeval est pat inf		E					
99392	Prev visit est age 1-4		E					
99393	Prev visit est age 5-11		E					
99394	Prev visit est age 12-17		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99395	Prev visit est age 18-39		E					
99396	Prev visit est age 40-64		E					
99397	Per pm reeval est pat 65+ yr		E					
99401	Preventive counseling indiv		E					
99402	Preventive counseling indiv		E					
99403	Preventive counseling indiv		E					
99404	Preventive counseling indiv		E					
99406	Behav chng smoking 3-10 min		X	0031	0.3010	$20.73	.	$4.15
99407	Behav chng smoking > 10 min		X	0031	0.3010	$20.73	.	$4.15
99408	Audit/dast 15-30 min		E					
99409	Audit/dast over 30 min		E					
99411	Preventive counseling group		E					
99412	Preventive counseling group		E					
99420	Health risk assessment test		E					
99429	Unlisted preventive service		E					
99441	Phone e/m by phys 5-10 min		E					
99442	Phone e/m by phys 11-20 min		E					
99443	Phone e/m by phys 21-30 min		E					
99444	Online e/m by phys		E					
99450	Basic life disability exam		E					
99455	Work related disability exam		B					
99456	Disability examination		B					
99460	Init nb em per day hosp		V	0605	1.0908	$75.13	.	$15.03
99461	Init nb em per day non-fac		M					
99462	Sbsq nb em per day hosp		C					
99463	Same day nb discharge		V	0605	1.0908	$75.13	.	$15.03
99464	Attendance at delivery		N					
99465	Nb resuscitation		S	0094	2.3671	$163.04	$45.71	$32.61
99466	Ped crit care transport		N					
99467	Ped crit care transport addl		N					
99468	Neonate crit care initial		C					
99469	Neonate crit care subsq		C					
99471	Ped critical care initial		C					
99472	Ped critical care subsq		C					
99475	Ped crit care age 2-5 init		C					
99476	Ped crit care age 2-5 subsq		C					
99477	Init day hosp neonate care		C					
99478	Ic lbw inf < 1500 gm subsq		C					
99479	Ic lbw inf 1500-2500 g subsq		C					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99480	Ic inf pbw 2501-5000 g subsq		C					
99499	Unlisted e&m service		B					
99500	Home visit prenatal		E					
99501	Home visit postnatal		E					
99502	Home visit nb care		E					
99503	Home visit resp therapy		E					
99504	Home visit mech ventilator		E					
99505	Home visit stoma care		E					
99506	Home visit im injection		E					
99507	Home visit cath maintain		E					
99509	Home visit day life activity		E					
99510	Home visit sing/m/fam couns		E					
99511	Home visit fecal/enema mgmt		E					
99512	Home visit for hemodialysis		E					
99600	Home visit nos		E					
99601	Home infusion/visit 2 hrs		E					
99602	Home infusion each addtl hr		E					
99605	Mtms by pharm np 15 min		E					
99606	Mtms by pharm est 15 min		E					
99607	Mtms by pharm addl 15 min		E					
0001F	Heart failure composite	CH	E					
0005F	Osteoarthritis composite	CH	E					
0012F	Cap bacterial assess	CH	E					
0014F	Comp preop assess cat surg	CH	E					
0015F	Melan follow-up complete	CH	E					
0016T	Thermotx choroid vasc lesion	CH	D					
0017T	Photocoagulat macular drusen	CH	D					
0019T	Extracorp shock wv tx ms nos		A					
0030T	Antiprothrombin antibody		A					
0042T	Ct perfusion w/contrast cbf		N					
0048T	Implant ventricular device		C					
0050T	Removal circulation assist		C					
0051T	Implant total heart system		C					
0052T	Replace component heart syst		C					
0053T	Replace component heart syst		C					
0054T	Bone surgery using computer		N					
0055T	Bone surgery using computer		N					
0058T	Cryopreservation ovary tiss		X	0344	0.8191	$56.42	$15.56	$11.29
0059T	Cryopreservation oocyte		X	0344	0.8191	$56.42	$15.56	$11.29

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0071T	U/s leiomyomata ablate <200		S	0067	49.4903	$3,408.69	.	$681.74
0072T	U/s leiomyomata ablate >200		S	0067	49.4903	$3,408.69	.	$681.74
0073T	Delivery comp imrt		S	0412	6.3625	$438.22	.	$87.65
0075T	Perq stent/chest vert art		C					
0076T	S&i stent/chest vert art		C					
0078T	Endovasc aort repr w/device		C					
0079T	Endovasc visc extnsn repr		C					
0080T	Endovasc aort repr rad s&i		C					
0081T	Endovasc visc extnsn s&i		C					
0085T	Breath test heart reject		E					
0092T	Artific disc addl		C					
0095T	Artific diskectomy addl		C					
0098T	Rev artific disc addl		C					
0099T	Implant corneal ring		T	0233	17.9021	$1,233.03	$263.12	$246.61
0100T	Prosth retina receive&gen		T	0672	40.9566	$2,820.93	.	$564.19
0101T	Extracorp shockwv tx hi enrg		T	0050	32.2439	$2,220.83	.	$444.17
0102T	Extracorp shockwv tx anesth		T	0050	32.2439	$2,220.83	.	$444.17
0103T	Holotranscobalamin		A					
0104T	At rest cardio gas rebreathe	CH	D					
0105T	Exerc cardio gas rebreathe	CH	D					
0106T	Touch quant sensory test		X	0341	0.0809	$5.57	$2.09	$1.12
0107T	Vibrate quant sensory test		X	0341	0.0809	$5.57	$2.09	$1.12
0108T	Cool quant sensory test		X	0341	0.0809	$5.57	$2.09	$1.12
0109T	Heat quant sensory test		X	0341	0.0809	$5.57	$2.09	$1.12
0110T	Nos quant sensory test		X	0341	0.0809	$5.57	$2.09	$1.12
0111T	Rbc membranes fatty acids		A					
0123T	Scleral fistulization		T	0234	24.4149	$1,681.60	$511.31	$336.32
0124T	Conjunctival drug placement		T	0232	2.5480	$175.50	$42.27	$35.10
0126T	Chd risk imt study		Q1	0340	0.6712	$46.23	.	$9.25
0130T	Chron care drug investigatn	CH	D					
0140T	Exhaled breath condensate ph	CH	D					
0141T	Perq islet transplant		E					
0142T	Open islet transplant		E					
0143T	Laparoscopic islet transplnt		E					
0155T	Lap impl gast curve electrd		T	0130	38.6514	$2,662.15	$659.53	$532.43
0156T	Lap remv gast curve electrd		T	0130	38.6514	$2,662.15	$659.53	$532.43
0157T	Open impl gast curve electrd		C					
0158T	Open remv gast curve electrd		C					
0159T	Cad breast mri		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0160T	Tcranial magn stim tx plan	CH	D					
0161T	Tcranial magn stim tx deliv	CH	D					
0163T	Lumb artif diskectomy addl		C					
0164T	Remove lumb artif disc addl		C					
0165T	Revise lumb artif disc addl		C					
0166T	Tcath vsd close w/o bypass		C					
0167T	Tcath vsd close w/bypass		C					
0168T	Rhinophototx light app bilat		T	0251	3.5538	$244.77	.	$48.96
0169T	Place stereo cath brain		C					
0171T	Lumbar spine proces distract		T	0052	88.9869	$6,129.06	.	$1,225.82
0172T	Lumbar spine process addl		T	0052	88.9869	$6,129.06	.	$1,225.82
0173T	Iop monit io pressure		N					
0174T	Cad cxr with interp		N					
0175T	Cad cxr remote		N					
0176T	Aqu canal dilat w/o retent	CH	D					
0177T	Aqu canal dilat w retent	CH	D					
0178T	64 lead ecg w/i&r		B					
0179T	64 lead ecg w/tracing		X	0100	2.5904	$178.42	$41.44	$35.69
0180T	64 lead ecg w/i&r only		B					
0181T	Corneal hysteresis		S	0230	0.6053	$41.69	.	$8.34
0182T	Hdr elect brachytherapy		S	0313	10.1646	$700.10	$264.73	$140.02
0183T	Wound ultrasound	CH	T	0015	1.4975	$103.14	.	$20.63
0184T	Exc rectal tumor endoscopic		C					
0185T	Comptr probability analysis		N					
0186T	Suprachoroidal drug delivery		T	0237	23.4306	$1,613.81	.	$322.77
0187T	Ophthalmic dx image anterior	CH	D					
0188T	Videoconf crit care 74 min		M					
0189T	Videoconf crit care addl 30		M					
0190T	Place intraoc radiation src		T	0237	23.4306	$1,613.81	.	$322.77
0191T	Insert ant segment drain int	CH	T	0673	43.2387	$2,978.11	$649.56	$595.63
0192T	Insert ant segment drain ext		T	0673	43.2387	$2,978.11	$649.56	$595.63
0193T	Rf bladder neck microremodel	CH	D					
0195T	Arthrod presac interbody		C					
0196T	Arthrod presac interbody eac		C					
0197T	Intrafraction track motion		N					
0198T	Ocular blood flow measure		S	0230	0.6053	$41.69	.	$8.34
0199T	Physiologic tremor record		S	0215	0.6518	$44.89	.	$8.98
0200T	Perq sacral augmt unilat inj		T	0049	22.9744	$1,582.38	.	$316.48
0201T	Perq sacral augmt bilat inj		T	0050	32.2439	$2,220.83	.	$444.17

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0202T	Post vert arthrplst 1 lumbar		C					
0203T	Unattend sleep study w/time	CH	D					
0204T	Unattended sleep study	CH	D					
0205T	Inirs each vessel add-on		N					
0206T	Remote algorithm analys ecg		Q1	0340	0.6712	$46.23	.	$9.25
0207T	Clear eyelid gland w/heat		S	0230	0.6053	$41.69	.	$8.34
0208T	Audiometry air only		X	0035	0.2674	$18.42	.	$3.69
0209T	Audiometry air & bone		X	0035	0.2674	$18.42	.	$3.69
0210T	Speech audiometry threshold		X	0035	0.2674	$18.42	.	$3.69
0211T	Speech audiom thresh & recog		X	0035	0.2674	$18.42	.	$3.69
0212T	Compre audiometry evaluation		X	0364	0.4748	$32.70	$7.06	$6.54
0213T	Njx paravert w/us cer/thor		T	0207	7.5886	$522.67	.	$104.54
0214T	Njx paravert w/us cer/thor		T	0204	2.6683	$183.78	$40.13	$36.76
0215T	Njx paravert w/us cer/thor		T	0204	2.6683	$183.78	$40.13	$36.76
0216T	Njx paravert w/us lumb/sac		T	0207	7.5886	$522.67	.	$104.54
0217T	Njx paravert w/us lumb/sac		T	0204	2.6683	$183.78	$40.13	$36.76
0218T	Njx paravert w/us lumb/sac		T	0204	2.6683	$183.78	$40.13	$36.76
0219T	Plmt post facet implt cerv		C					
0220T	Plmt post facet implt thor		C					
0221T	Plmt post facet implt lumb		T	0050	32.2439	$2,220.83	.	$444.17
0222T	Plmt post facet implt addl		T	0050	32.2439	$2,220.83	.	$444.17
0223T	Acoustic ecg w/i&r		S	0099	0.3958	$27.26	.	$5.46
0224T	Acoustic ecg 1+ analysis		S	0690	0.5093	$35.08	$8.67	$7.02
0225T	Acoustic ecg analy & reprog		S	0690	0.5093	$35.08	$8.67	$7.02
0226T	Anoscopy hra w/spec collect		X	0340	0.6712	$46.23	.	$9.25
0227T	Anoscopy hra w/biopsy		T	0146	5.7982	$399.36	.	$79.88
0228T	Njx tfrml eprl w/us cer/thor		T	0207	7.5886	$522.67	.	$104.54
0229T	Njx tfrml eprl w/us cer/thor		T	0206	3.8823	$267.40	.	$53.48
0230T	Njx tfrml eprl w/us lumb/sac		T	0207	7.5886	$522.67	.	$104.54
0231T	Njx tfrml eprl w/us lumb/sac		T	0206	3.8823	$267.40	.	$53.48
0232T	Njx platelet plasma		X	0340	0.6712	$46.23	.	$9.25
0233T	Skin glycation spectroscopy		A					
0234T	Trluml perip athrc renal art	NI	T	0082	92.7252	$6,386.54	.	$1,277.31
0235T	Trluml perip athrc visceral	NI	C					
0236T	Trluml perip athrc abd aorta	NI	T	0082	92.7252	$6,386.54	.	$1,277.31
0237T	Trluml perip athrc brchiocph	NI	T	0082	92.7252	$6,386.54	.	$1,277.31
0238T	Trluml perip athrc iliac art	NI	T	0082	92.7252	$6,386.54	.	$1,277.31
0239T	Bioimpedance spectroscopy	NI	S	0099	0.3958	$27.26	.	$5.46
0240T	Esoph motility 3d topography	NI	X	0361	4.1013	$282.48	$83.23	$56.50

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0241T	Esoph motility w/stim/perf	NI	X	0361	4.1013	$282.48	$83.23	$56.50
0242T	Gi tract transit & pres meas	NI	X	0361	4.1013	$282.48	$83.23	$56.50
0243T	Intm msr bronchodil wheeze	NI	S	0078	1.4318	$98.62	.	$19.73
0244T	Cont msr bronchodil wheeze	NI	S	0369	3.0144	$207.62	$42.19	$41.53
0245T	Opn tx rib fx 1-2 ribs	NI	T	0062	26.5543	$1,828.95	$372.87	$365.79
0246T	Opn tx rib fx 3-4 ribs	NI	T	0062	26.5543	$1,828.95	$372.87	$365.79
0247T	Opn tx rib fx 5-6 ribs	NI	T	0062	26.5543	$1,828.95	$372.87	$365.79
0248T	Opn tx rib fx 7+ ribs	NI	T	0062	26.5543	$1,828.95	$372.87	$365.79
0249T	Ligation hemorrhoid w/us	NI	T	0155	16.1126	$1,109.77	.	$221.96
0250T	Insert bronchial valve	NI	T	0415	28.6278	$1,971.77	$459.92	$394.36
0251T	Remov bronchial valve addl	NI	T	0076	10.5006	$723.24	$189.82	$144.65
0252T	Bronchscpc rmvl bronch valve	NI	T	0076	10.5006	$723.24	$189.82	$144.65
0253T	Insert aqueous drain device	NI	T	0234	24.4149	$1,681.60	$511.31	$336.32
0254T	Evasc rpr iliac art bifur	NI	C					
0255T	Evasc rpr iliac art bifr s&i	NI	C					
0256T	Evasc aortic hrt valve	NI	C					
0257T	Opn tthrc aortic hrt valve	NI	C					
0258T	Aortic hrt valv w/o card byp	NI	C					
0259T	Aortic hrt valve w/card byp	NI	C					
0260T	Hypthrm bdy neonate 28d/<	NI	N					
0261T	Hypthrm head neonate 28d/<	NI	N					
0500F	Initial prenatal care visit	CH	E					
0501F	Prenatal flow sheet	CH	E					
0502F	Subsequent prenatal care	CH	E					
0503F	Postpartum care visit	CH	E					
0505F	Hemodialysis plan docd		M					
0507F	Periton dialysis plan docd		M					
0509F	Urine incon plan docd		M					
0513F	Elev bp plan of care docd		M					
0514F	Care plan hgb docd esa pt		M					
0516F	Anemia plan of care docd	CH	E					
0517F	Glaucoma plan of care docd		M					
0518F	Fall plan of care docd		M					
0519F	Pland chemo docd b/4 txmnt	CH	E					
0520F	Rad dos limts b/4 3d rad		M					
0521F	Plan of care 4 pain docd		M					
0525F	Initial visit for episode	CH	E					
0526F	Subs visit for episode		M					
0528F	Remnd flw-up 10 yrs docd		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0529F	Intrvl 3+yrs pts clnscp docd		M					
0535F	Dyspnea mngmnt plan docd		E					
0540F	Gluco mngmnt plan docd		M					
0545F	Follow up care plan mdd docd		E					
0575F	HIV rna plan care docd		M					
1000F	Tobacco use assessed	CH	E					
1002F	Assess anginal symptom/level		M					
1003F	Level of activity assess	CH	E					
1004F	Clin symp vol ovrld assess	CH	E					
1005F	Asthma symptoms evaluate		M					
1006F	Osteoarthritis assess		M					
1007F	Anti-inflm/anlgsc otc assess		M					
1008F	Gi/renal risk assess	CH	E					
1015F	Copd symptoms assess	CH	E					
1018F	Assess dyspnea not present	CH	E					
1019F	Assess dyspnea present	CH	E					
1022F	Pneumo imm status assess	CH	E					
1026F	Co-morbid condition assess	CH	E					
1030F	Influenza imm status assess	CH	E					
1034F	Current tobacco smoker	CH	E					
1035F	Smokeless tobacco user	CH	E					
1036F	Tobacco non-user		M					
1038F	Persistent asthma		M					
1039F	Intermittent asthma		M					
1040F	Dsm-iv info mdd docd		M					
1050F	History of mole changes	CH	E					
1055F	Visual funct status assess	CH	E					
1060F	Doc perm/cont/parox atr fib	CH	E					
1061F	Doc lack perm+cont+parox fib	CH	E					
1065F	Ischm stroke symp lt3 hrsb/4	CH	E					
1066F	Ischm stroke symp ge3 hrsb/4	CH	E					
1070F	Alarm symp assessed-absent	CH	E					
1071F	Alarm symp assessed-1+ prsnt	CH	E					
1090F	Pres/absn urine incon assess		M					
1091F	Urine incon characterized		M					
1100F	Ptfalls assess-docd ge2+/yr		M					
1101F	Pt falls assess-docd le1/yr		M					
1110F	Pt lft inpt fac w/in 60 days		M					
1111F	Dschrg med/current med merge		M					
1116F	Auric/peri pain assessed		M					
1118F	GERD symps assessed 12 month	CH	E					
1119F	Init eval for condition		M					
1121F	Subs eval for condition		M					
1123F	Acp discuss/dscn rnkr docd		M					
1124F	Acp discuss-no dscnmkr docd		M					
1125F	Amnt pain noted pain prsnt		M					
1126F	Amnt pain noted none prsnt		M					
1130F	Bk pain + fxn assessed		M					
1134F	Epsd bk pain for =< 6 wks	CH	E					
1135F	Epsd bk pain for > 6 wks	CH	E					
1136F	Epsd bk pain for <= 12 wks	CH	E					
1137F	Epsd bk pain for > 12 wks	CH	E					
1150F	Doc pt rsk death w/in 1yr		E					
1151F	Doc no pt rsk death w/in 1yr		E					
1152F	Doc advncd dis comfort 1st		E					
1153F	Doc advncd dis cmfrt not 1st		E					
1157F	Advnc care plan in rcrd		E					
1158F	Advnc care plan tlk docd		M					
1159F	Med list docd in rcrd		E					
1160F	Rvw meds by rx/dr in rcrd		E					
1170F	Fxnl status assessed		M					
1180F	Thromboemb risk assessed		E					
1200F	Seizure type& frequ docd		E					
1205F	EPI etiol synd rvwd and docd		E					
1220F	Pt screened for depression	CH	E					
1400F	Prkns diag rviewed	NI	E					
2000F	Blood pressure measure		M					
2001F	Weight record	CH	E					
2002F	Clin sign vol ovrld assess	CH	E					
2004F	Initial exam involved joints	CH	E					
2010F	Vital signs recorded		M					
2014F	Mental status assess		M					
2018F	Hydration status assess	CH	E					
2019F	Dilated macul exam done		M					
2020F	Dilated fundus eval done	CH	E					
2021F	Dilat macul+ exam done		M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
2022F	Dil retina exam interp rev		M					
2024F	7 field photo interp doc rev		M					
2026F	Eye image valid to dx rev		M					
2027F	Optic nerve head eval done		M					
2028F	Foot exam performed		M					
2029F	Complete phys skin exam done	CH	E					
2030F	H2o stat docd normal	CH	E					
2031F	H2o stat docd dehydrated	CH	E					
2035F	Tymp memb motion examd		M					
2040F	Bk pn xm on init visit date		M					
2044F	Doc mntl tst b/4 bk trxmnt	CH	E					
2050F	Wound char size etc docd		E					
2060F	Pt talk eval hlthwkr re mdd		E					
3006F	Cxr doc rev	CH	E					
3008F	Body mass index docd		E					
3011F	Lipid panel doc rev	CH	E					
3014F	Screen mammo doc rev		M					
3015F	Cerv cancer screen docd		E					
3016F	Pt scrnd unhlthy OH use		M					
3017F	Colorectal ca screen doc rev		M					
3018F	Pre-prxd rsk et al docd		E					
3020F	Lvf assess		M					
3021F	Lvef mod/sever deprs syst		M					
3022F	Lvef >=40% systolic		M					
3023F	Spirom doc rev		M					
3025F	Spirom fev/fvc<70% w/copd		M					
3027F	Spirom fev/fvc>=70%/w/o copd		M					
3028F	O2 saturation doc rev		M					
3035F	O2 saturation<=88% /pao<=55	CH	E					
3037F	O2 saturation> 88% /pao>55	CH	E					
3038F	Pulm fx w/in 12 mon b/4 surg	CH	M					
3040F	Fev<40% predicted value	CH	E					
3042F	Fev>=40% predicted value	CH	E					
3044F	Hg a1c level lt 7.0%		M					
3045F	Hg a1c level 7.0-9.0%		M					
3046F	Hemoglobin a1c level > 9.0%		M					
3048F	Ldl-c <100 mg/dl		M					
3049F	Ldl-c 100-129 mg/dl		M					
3050F	Ldl-c >= 130 mg/dl		M					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3060F	Pos microalbuminuria rev		M					
3061F	Neg microalbuminuria rev		M					
3062F	Pos macroalbuminuria rev		M					
3066F	Nephropathy doc tx		M					
3072F	Low risk for retinopathy		M					
3073F	Pre-surg eye measures docd	CH	E					
3074F	Syst bp lt 130 mm hg		M					
3075F	Syst bp ge 130 - 139mm hg		M					
3077F	Syst bp >= 140 mm hg		M					
3078F	Diast bp < 80 mm hg		M					
3079F	Diast bp 80-89 mm hg		M					
3080F	Diast bp >= 90 mm hg		M					
3082F	Kt/v <1.2		M					
3083F	Kt/v > 1.2 <1.7		M					
3084F	Kt/v ge 1.7		M					
3085F	Suicide risk assessed		M					
3088F	Mdd mild	CH	E					
3089F	Mdd moderate	CH	E					
3090F	Mdd severe w/o psych	CH	E					
3091F	Mdd severe w/psych	CH	E					
3092F	Mdd in remission		M					
3093F	Doc new diag 1st/addl mdd	CH	E					
3095F	Central dexa results docd		M					
3096F	Central dexa ordered		M					
3100F	Image test ref carot diam		M					
3110F	Pres/absn hmrhg/lesion docd		M					
3111F	Ct/mri brain done w/in 24hrs		M					
3112F	Ct/mri brain done >24 hrs		M					
3120F	12-lead ecg performed		M					
3130F	Upper gi endoscopy performed	CH	E					
3132F	Doc ref upper gi endoscopy	CH	E					
3140F	Upper gi endo shows barrtts	CH	E					
3141F	Upper gi endo not barrtts	CH	E					
3142F	Barium swallow test ordered	CH	E					
3150F	Forceps esoph biopsy done	CH	E					
3155F	Cytogen test marrow b/4 tx		M					
3160F	Doc fe+ stores b/4 epo thx		M					
3170F	Flow cyto done b/4 tx		M					
3200F	Barium swallow test not req	CH	E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3210F	Grp a strep test performed		M					
3215F	Pt immunity to hep a docd		M					
3216F	Pt immunity to hep b docd		M					
3218F	Rna tstng hep c docd done		M					
3220F	Hep c quant rna tstng docd		M					
3230F	Note hring tst w/in 6 mon	CH	E					
3250F	Nonprim loc anat bx site tum		M					
3260F	Pt cat/pn cat/hist grd docd		M					
3265F	Rna tstng hepc vir ord/docd		M					
3266F	Hepc gn tstng docd b/4txmnt		M					
3268F	Psa/t/glsc docd b/4 txmnt	CH	E					
3269F	Bone scn b/4 txmnt/aftr Dx		M					
3270F	No bone scn b/4 txmnt/aftrDx		M					
3271F	Low risk prostate cancer		M					
3272F	Med risk prostate cancer		M					
3273F	High risk prostate cancer		M					
3274F	Prost Cncr rsk not lw/md/hgh		M					
3278F	Serum lvls CA/iPTH/lpd ord		M					
3279F	Hgb lvl >/= 13 g/dl		M					
3280F	Hgb lvl 11-12.9 g/dL		M					
3281F	Hgb lvl < 11 g/dl		M					
3284F	Iop down >15% of pre-svc lvl		M					
3285F	IOP down <15% of pre-svc lvl		M					
3288F	Fall risk assessment docd		M					
3290F	Pt=D(Rh)- and unsensitized	CH	E					
3291F	Pt=d(rh)+ or sensitized	CH	E					
3292F	Hiv tstng asked/docd/revwd	CH	E					
3293F	Abo rh blood typing docd		E					
3294F	Grp b strep screening docd		E					
3300F	AJCC stage docd b/4 thxpy		M					
3301F	Cancer stage docd metast		M					
3315F	Er+ or pr+ breast cancer		M					
3316F	ER- or PR- breast cancer		M					
3317F	Path rpt malig cancer docd	CH	E					
3318F	Path rpt malig cancer docd	CH	E					
3319F	X-ray/ct/ultrsnd et al ord		M					
3320F	No xray/ct/ et al ordd		M					
3321F	AJCC cncr 0/IA melan docd	CH	M					
3322F	Melanoma>ajcc stage 0 or ia	CH	M					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3323F	Clin node stgng docdb/4 surg		M					
3324F	Mri ct scan ord rvwd rqstd		E					
3325F	Preop asses 4 cataract surg	CH	E					
3328F	Prfrmnc docd 2 wks b/4 surg	CH	M					
3330F	Imaging study ordered (bkp)	CH	E					
3331F	Bk imaging tst not ordered	CH	E					
3340F	Mammo assess inc xray docd		M					
3341F	Mammo assess negative docd		M					
3342F	Mammo assess bengn docd		M					
3343F	Mammo probably bengn docd		M					
3344F	Mammo assess susp docd		M					
3345F	Mammo assess hghlymalig doc		M					
3350F	Mammo bx proven malig docd		M					
3351F	Neg scrn dep symp by deptool		E					
3352F	No sig dep symp by dep tool		E					
3353F	Mild-mod dep symp by deptool		E					
3354F	Clin sig dep sym by dep tool		E					
3370F	AJCC brst cncr stage 0 docd		M					
3372F	Ajcc brst cncr stage 1 docd		M					
3374F	Ajcc brst cncr stage 1 docd		M					
3376F	AJCC brstcncr stage 2 docd		M					
3378F	AJCC brstcncr stage 3 docd		M					
3380F	AJCC brstcncr stage 4 docd		M					
3382F	AJCC cln cncr stage 0 docd		M					
3384F	AJCC cln cncr stage 1 docd		M					
3386F	AJCC cln cncr stage 2 docd		M					
3388F	AJCC cln cncr stage 3 docd		M					
3390F	AJCC cln cncr stage 4 docd		M					
3450F	Dyspnea scrnd no-mild dysp		E					
3451F	Dyspnea scrnd mod-high dysp		E					
3452F	Dyspnea not screened		E					
3455F	TB scrng done-interpd 6mon		M					
3470F	Ra disease activity low		M					
3471F	Ra disease activity mod		M					
3472F	Ra disease activity high		M					
3475F	Disease progn RA poor docd		M					
3476F	Disease progn RA good docd		M					
3490F	History aids-defining cond		M					
3491F	HIV unsure baby of HIV+moms		E					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3492F	History cd4+ cell count <350		M					
3493F	No hist cd4+ cell count<350		M					
3494F	CD4+cell count <200cells/mm3		M					
3495F	Cd4+cell cnt 200-499 cells		M					
3496F	Cd4+ cell count + 500 cells		M					
3497F	CD4+ cell percentage <15%		E					
3498F	Cd4+ cell % >=15% (hiv)		E					
3500F	Cd4+cell cnt/% docd as done		M					
3502F	HIV rna vrl ld <lmts quantif		M					
3503F	HIV rna vrl ldnot<lmts quntf		M					
3510F	Doc tb scrng-rslts interpd		E					
3511F	Chlmyd/gonrh tsts docd done		M					
3512F	Syph scrng docd as done		M					
3513F	Hep B scrng docd as done		E					
3514F	Hep C scrng docd as done		E					
3515F	Pt has docd immun to hep C		E					
3550F	Low rsk thromboembolism		E					
3551F	Intrmed rsk thromboembolism		E					
3552F	Hgh risk for thromboembolism		E					
3555F	Pt inr measurement performed		E					
3570F	Rprt bone scint xref w xray		M					
3572F	Pt consid poss risk fx		E					
3573F	Pt not consid poss risk fx		E					
3650F	Eeg ordered rvwd reqstd		E					
3700F	Psych disorders assessed	NI	E					
3720F	Cognit impairment assessed	NI	E					
4000F	Tobacco use txmnt counseling		M					
4001F	Tobacco use txmnt pharmacol		M					
4002F	Statin therapy rx		M					
4003F	Pt ed write/oral pts w/ hf		M					
4004F	Pt tobacco screen rcvd tlk	CH	M					
4005F	Pharm thx for op rxd		M					
4006F	Beta-blocker therapy rx		M					
4009F	Ace/arb inhibitor therapy rx		M					
4011F	Oral antiplatelet therapy rx		M					
4012F	Warfarin therapy rx		M					
4014F	Written discharge instr prvd	CH	E					
4015F	Persist asthma medicine ctrl		M					
4016F	Anti-inflm/anlgsc agent rx	CH	E					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4017F	Gi prophylaxis for nsaid rx	CH	E					
4018F	Therapy exercise joint rx	CH	E					
4019F	Doc recpt counsl vit d/calc+	CH	E					
4025F	Inhaled bronchodilator rx		M					
4030F	Oxygen therapy rx	CH	E					
4033F	Pulmonary rehab rec	CH	E					
4035F	Influenza imm rec	CH	E					
4037F	Influenza imm order/admin		M					
4040F	Pneumoc vac/admin/rcvd		M					
4041F	Doc order cefazolin/cefurox		M					
4042F	Doc antibio not given		M					
4043F	Doc order given stop antibio		M					
4044F	Doc order given vte prophylx		M					
4045F	Empiric antibiotic rx		M					
4046F	Doc antibio given b/4 surg		M					
4047F	Doc antibio given b/4 surg		M					
4048F	Doc antibio given b/4 surg		M					
4049F	Doc order given stop antibio		M					
4050F	Ht care plan doc		M					
4051F	Referred for an AV fistula		M					
4052F	Hemodialysis via AV fistula	CH	E					
4053F	Hemodialysis via AV graft	CH	E					
4054F	Hemodialysis via catheter	CH	E					
4055F	Pt rcvng periton dialysis	CH	E					
4056F	Approp oral rehyd recommd	CH	E					
4058F	Ped gastro ed given caregvr	CH	E					
4060F	Psych svcs provided	CH	E					
4062F	Pt referral psych docd	CH	E					
4063F	Antidepres rxthxpy not rxd		E					
4064F	Antidepressant rx	CH	E					
4065F	Antipsychotic rx	CH	E					
4066F	ECT provided	CH	E					
4067F	Pt referral for ect docd	CH	E					
4070F	Dvt prophylx recvd day 2		M					
4073F	Oral antiplat thx rx dischrg		M					
4075F	Anticoag thx rx at dischrg		M					
4077F	Doc t-pa admin considered	CH	E					
4079F	Doc rehab svcs considered		M					
4084F	Aspirin recvd w/in 24 hrs		M					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4090F	Pt rcvng epo thxpy		M					
4095F	Pt not rcvng epo thxpy		M					
4100F	Biphos thxpy vein ord/recvd		M					
4110F	Int mam art used for cabg		M					
4115F	Beta blckr admin w/in 24 hrs		M					
4120F	Antibiot rxd/given		M					
4124F	Antibiot not rxd/given		M					
4130F	Topical prep rx aoe		M					
4131F	Syst antimicrobial thx rx		M					
4132F	No syst antimicrobial thx rx		M					
4133F	Antihist/decong rx/recom	CH	E					
4134F	No antihist/decong rx/recom	CH	E					
4135F	Systemic corticosteroids rx	CH	E					
4136F	Syst corticosteroids not rx	CH	E					
4148F	Hep A vac injxn admin/recvd		M					
4149F	Hep B vac injxn admin/recvd		M					
4150F	Pt recvng antivir txmnt hepc		M					
4151F	Pt not recvng antiv hep c		M					
4153F	Combo pegintf/rib rx		M					
4155F	Hep A vac series prev recvd	CH	E					
4157F	Hep B vac series prev recvd	CH	E					
4158F	Pt edu re alcoh drnkng done		M					
4159F	Contrcp talk b/4 antiv txmnt		M					
4163F	Pt couns 4 txmnt opt prost	CH	E					
4164F	Adjv hrmnl thxpy rxd		M					
4165F	3d-crt/imrt received		M					
4167F	Hd bed tilted 1st day vent	CH	E					
4168F	Pt care icu&vent w/in 24hrs	CH	E					
4169F	No pt care ICU/vent in 24hrs	CH	E					
4171F	Pt rcvng esa thxpy		M					
4172F	Pt not rcvng esa thxpy		M					
4174F	Couns potent glauc impct	CH	E					
4175F	Vis of >= 20/40 w/in 90 days		M					
4176F	Talk re uv light pt/crgvr	CH	E					
4177F	Talk pt/crgvr re areds prev		M					
4178F	Antid glbln rcvd w/in 26wks	CH	E					
4179F	Tamoxifen/AI prescribed		M					
4180F	Adjv thxpyrxd/rcvd colon ca		M					
4181F	Conformal radn thxpy rcvd	CH	E					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4182F	No conformal radn thxpy	CH	E					
4185F	Continuous ppi or h2ra rcvd	CH	E					
4186F	No cont ppi or h2ra rcvd	CH	E					
4187F	Anti rheum drugthxpyrxd/gvn		M					
4188F	Approp ACE/ARB tstng done	CH	E					
4189F	Approp digoxin tstng done	CH	E					
4190F	Approp diuretic tstng done	CH	E					
4191F	Approp anticonvuls tstng	CH	E					
4192F	Pt not rcvng glucoco thxpy		M					
4193F	Pt rcvng<10mg daily predniso		M					
4194F	Pt rcvng>10mg daily predniso		M					
4195F	Pt rcvng anti-rheum thxpy RA		M					
4196F	Ptnot rcvng anti-rhm thxpyRA		M					
4200F	External beam to prost only		M					
4201F	Extml beam other than prost		M					
4210F	ACE/ARB thxpy for >= 6 mons	CH	E					
4220F	Digoxin thxpy for >= 6 mons	CH	E					
4221F	Diuretic thxpy for >= 6 mons	CH	E					
4230F	Anticonv thxpy for >= 6 mons	CH	E					
4240F	Instr xrcz 4bk pn >12 weeks	CH	E					
4242F	Sprvsd xrcz bk pn >12 weeks	CH	E					
4245F	Pt instr nrml lifest		M					
4248F	Pt instr no bd rest>= 4 days		M					
4250F	Wrmng 4 surg normothermia		M					
4255F	Anesth 60+ min as docd		M					
4256F	Anesthe <60 min as docd		M					
4260F	Wound srfc culturetech used		E					
4261F	Tech other than surfc cultr		E					
4265F	Wet-dry dressings rx recmd		E					
4266F	No wet-dry drssings rx recmd		E					
4267F	Comprssion thxpy prescribed		M					
4268F	Pt ed re comp thxpy rcvd		E					
4269F	Appropos mthd offloading Rxd		E					
4270F	Pt rcvng anti r-viral thxpy		M					
4271F	Pt rcvng anti r-viral thxpy		M					
4274F	Flu immuno admind rcvd		M					
4275F	Hep b vac inj admin/rcvd		E					
4276F	Potent antivir thxpy Rxd		M					
4279F	PCP prophylaxis Rxd		E					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4280F	PCP prophylax Rxd 3mon low %		M					
4290F	Pt scrned for inj drug use		M					
4293F	Pt scrnd hgh-risk sex behav		M					
4300F	Pt rcvng warf thxpy		E					
4301F	Pt not rcvng warf thxpy		E					
4305F	Pt ed re ft care inspct rcvd		E					
4306F	Pt tlk psych & Rx opd addic		E					
4320F	Pt talk psychsoc&rx oh dpnd		E					
4324F	Pt queried prkns complic	NI	E					
4325F	Med txmnt options rvwd w/pt	NI	E					
4326F	Pt asked re symp auto dysfxn	NI	E					
4328F	Pt asked re sleep disturb	NI	E					
4330F	Cnslng epi spec sfty issues		E					
4340F	Cnslng chldbrng women epi		E					
4400F	Rehab thxpy options w/pt	NI	E					
5005F	Pt counsld on exam for moles	CH	E					
5010F	Macul result to phy mng dm		M					
5015F	Doc fx & test/txmnt for op		M					
5020F	Txmnts 2 main Dr by 1 mon		E					
5050F	Plan 2 main dr by 1 month		M					
5060F	Fndngs mammo 2pt w/in 3 days	CH	E					
5062F	Mammo result com to pt 5 day	CH	E					
5100F	Rsk fx ref w/n 24 hrs xray		E					
5200F	Eval appros surg thxpy epi		E					
6005F	Care level rationale doc	CH	E					
6010F	Dysphag test done b/4 eating		M					
6015F	Dysphag test done b/4 eating		M					
6020F	Npo (nothing-mouth) ordered		M					
6030F	Max sterile barriers follwd		M					
6040F	Appro rad ds dvcs techs docd	CH	E					
6045F	Radxps in end rprt4fluro pxd		M					
6070F	Pt asked/cnsld aed effects		E					
6080F	Pt/caregiver queried falls	NI	E					
6090F	Pt/caregiver counsel safety	NI	E					
7010F	Pt info into recall system		M					
7020F	Mammo assess cat in dbase	CH	E					
7025F	Pt infosys alarm 4 nxt mammo		M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A0021	Outside state ambulance serv		E					
A0080	Noninterest escort in non er		E					
A0090	Interest escort in non er		E					
A0100	Nonemergency transport taxi		E					
A0110	Nonemergency transport bus		E					
A0120	Noner transport mini-bus		E					
A0130	Noner transport wheelch van		E					
A0140	Nonemergency transport air		E					
A0160	Noner transport case worker		E					
A0170	Transport parking fees/tolls		E					
A0180	Noner transport lodgng recip		E					
A0190	Noner transport meals recip		E					
A0200	Noner transport lodgng escrt		E					
A0210	Noner transport meals escort		E					
A0225	Neonatal emergency transport		E					
A0380	Basic life support mileage		E					
A0382	Basic support routine suppls		A					
A0384	Bls defibrillation supplies		A					
A0390	Advanced life support mileag		E					
A0392	Als defibrillation supplies		A					
A0394	Als IV drug therapy supplies		A					
A0396	Als esophageal intub suppls		A					
A0398	Als routine disposble suppls		A					
A0420	Ambulance waiting 1/2 hr		A					
A0422	Ambulance 02 life sustaining		A					
A0424	Extra ambulance attendant		A					
A0425	Ground mileage		A					
A0426	Als 1		A					
A0427	ALS1-emergency		A					
A0428	bls		A					
A0429	BLS-emergency		A					
A0430	Fixed wing air transport		A					
A0431	Rotary wing air transport		A					
A0432	Pl volunteer ambulance co		A					
A0433	als 2		A					
A0434	Specialty care transport		A					
A0435	Fixed wing air mileage		A					
A0436	Rotary wing air mileage		A					
A0888	Noncovered ambulance		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	mileage							
A0998	Ambulance response/treatment		E					
A0999	Unlisted ambulance service		A					
A4206	1 CC sterile syringe&needle		E					
A4207	2 CC sterile syringe&needle		E					
A4208	3 CC sterile syringe&needle		E					
A4209	5+ CC sterile syringe&needle		E					
A4210	Nonneedle injection device		E					
A4211	Supp for self-adm injections		E					
A4212	Non coring needle or stylet		B					
A4213	20+ CC syringe only		E					
A4215	Sterile needle		E					
A4216	Sterile water/saline, 10 ml		A					
A4217	Sterile water/saline, 500 ml		A					
A4218	Sterile saline or water		N					
A4220	Infusion pump refill kit		N					
A4221	Maint drug infus cath per wk		Y					
A4222	Infusion supplies with pump		Y					
A4223	Infusion supplies w/o pump		E					
A4230	Infus insulin pump non needl		N					
A4231	Infusion insulin pump needle		N					
A4232	Syringe w/needle insulin 3cc		E					
A4233	Alkalin batt for glucose mon		Y					
A4234	J-cell batt for glucose mon		Y					
A4235	Lithium batt for glucose mon		Y					
A4236	Silvr oxide batt glucose mon		Y					
A4244	Alcohol or peroxide per pint		E					
A4245	Alcohol wipes per box		E					
A4246	Betadine/phisohex solution		E					
A4247	Betadine/iodine swabs/wipes		E					
A4248	Chlorhexidine antisept		N					
A4250	Urine reagent strips/tablets		E					
A4252	Blood ketone test or strip		E					
A4253	Blood glucose/reagent strips		Y					
A4255	Glucose monitor platforms		Y					
A4256	Calibrator solution/chips		Y					
A4257	Replace Lensshield Cartridge		Y					
A4258	Lancet device each		Y					
A4259	Lancets per box		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4261	Cervical cap contraceptive		E					
A4262	Temporary tear duct plug		N					
A4263	Permanent tear duct plug		N					
A4264	Intratubal occlusion device		E					
A4265	Paraffin		Y					
A4266	Diaphragm		E					
A4267	Male condom		E					
A4268	Female condom		E					
A4269	Spermicide		E					
A4270	Disposable endoscope sheath		N					
A4280	Brst prsths adhsv attchmnt		A					
A4281	Replacement breastpump tube		E					
A4282	Replacement breastpump adpt		E					
A4283	Replacement breastpump cap		E					
A4284	Replcmnt breast pump shield		E					
A4285	Replcmnt breast pump bottle		E					
A4286	Replcmnt breastpump lok ring		E					
A4290	Sacral nerve stim test lead		B					
A4300	Cath impl vasc access portal		N					
A4301	Implantable access syst perc		N					
A4305	Drug delivery system >=50 ML		N					
A4306	Drug delivery system <=50 ml		N					
A4310	Insert tray w/o bag/cath		A					
A4311	Catheter w/o bag 2-way latex		A					
A4312	Cath w/o bag 2-way silicone		A					
A4313	Catheter w/bag 3-way		A					
A4314	Cath w/drainage 2-way latex		A					
A4315	Cath w/drainage 2-way silcne		A					
A4316	Cath w/drainage 3-way		A					
A4320	Irrigation tray		A					
A4321	Cath therapeutic irrig agent		A					
A4322	Irrigation syringe		A					
A4326	Male external catheter		A					
A4327	Fem urinary collect dev cup		A					
A4328	Fem urinary collect pouch		A					
A4330	Stool collection pouch		A					
A4331	Extension drainage tubing		A					
A4332	Lube sterile packet		A					
A4333	Urinary cath anchor device		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4334	Urinary cath leg strap		A					
A4335	Incontinence supply		A					
A4336	Urethral insert		A					
A4338	Indwelling catheter latex		A					
A4340	Indwelling catheter special		A					
A4344	Cath indw foley 2 way silicn		A					
A4346	Cath indw foley 3 way		A					
A4349	Disposable male external cat		A					
A4351	Straight tip urine catheter		A					
A4352	Coude tip urinary catheter		A					
A4353	Intermittent urinary cath		A					
A4354	Cath insertion tray w/bag		A					
A4355	Bladder irrigation tubing		A					
A4356	Ext ureth clmp or compr dvc		A					
A4357	Bedside drainage bag		A					
A4358	Urinary leg or abdomen bag		A					
A4360	Disposable ext urethral dev		A					
A4361	Ostomy face plate		A					
A4362	Solid skin barrier		A					
A4363	Ostomy clamp, replacement		A					
A4364	Adhesive, liquid or equal		A					
A4366	Ostomy vent		A					
A4367	Ostomy belt		A					
A4368	Ostomy filter		A					
A4369	Skin barrier liquid per oz		A					
A4371	Skin barrier powder per oz		A					
A4372	Skin barrier solid 4x4 equiv		A					
A4373	Skin barrier with flange		A					
A4375	Drainable plastic pch w fcpl		A					
A4376	Drainable rubber pch w fcplt		A					
A4377	Drainable plstic pch w/o fp		A					
A4378	Drainable rubber pch w/o fp		A					
A4379	Urinary plastic pouch w fcpl		A					
A4380	Urinary rubber pouch w fcplt		A					
A4381	Urinary plastic pouch w/o fp		A					
A4382	Urinary hvy plstc pch w/o fp		A					
A4383	Urinary rubber pouch w/o fp		A					
A4384	Ostomy faceplt/silicone ring		A					
A4385	Ost skn barrier sld ext wear		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4387	Ost clsd pouch w att st barr		A					
A4388	Drainable pch w ex wear barr		A					
A4389	Drainable pch w st wear barr		A					
A4390	Drainable pch ex wear convex		A					
A4391	Urinary pouch w ex wear barr		A					
A4392	Urinary pouch w st wear barr		A					
A4393	Urine pch w ex wear bar conv		A					
A4394	Ostomy pouch liq deodorant		A					
A4395	Ostomy pouch solid deodorant		A					
A4396	Peristomal hernia supprt blt		A					
A4397	Irrigation supply sleeve		A					
A4398	Ostomy irrigation bag		A					
A4399	Ostomy irrig cone/cath w brs		A					
A4400	Ostomy irrigation set		A					
A4402	Lubricant per ounce		A					
A4404	Ostomy ring each		A					
A4405	Nonpectin based ostomy paste		A					
A4406	Pectin based ostomy paste		A					
A4407	Ext wear ost skn barr <=4sq"		A					
A4408	Ext wear ost skn barr >4sq"		A					
A4409	Ost skn barr convex <=4 sq i		A					
A4410	Ost skn barr extnd >4 sq		A					
A4411	Ost skn barr extnd =4sq		A					
A4412	Ost pouch drain high output		A					
A4413	2 pc drainable ost pouch		A					
A4414	Ost sknbar w/o conv<=4 sq in		A					
A4415	Ost skn barr w/o conv >4 sqi		A					
A4416	Ost pch clsd w barrier/filtr		A					
A4417	Ost pch w bar/bltinconv/fltr		A					
A4418	Ost pch clsd w/o bar w filtr		A					
A4419	Ost pch for bar w flange/flt		A					
A4420	Ost pch clsd for bar w lk fl		A					
A4421	Ostomy supply misc		E					
A4422	Ost pouch absorbent material		A					
A4423	Ost pch for bar w lk fl/fltr		A					
A4424	Ost pch drain w bar & filter		A					
A4425	Ost pch drain for barrier fl		A					
A4426	Ost pch drain 2 piece system		A					
A4427	Ost pch drain/barr lk flng/f		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4428	Urine ost pouch w faucet/tap		A					
A4429	Urine ost pouch w bltinconv		A					
A4430	Ost urine pch w b/bltin conv		A					
A4431	Ost pch urine w barrier/tapv		A					
A4432	Os pch urine w bar/fange/tap		A					
A4433	Urine ost pch bar w lock fln		A					
A4434	Ost pch urine w lock flng/ft		A					
A4450	Non-waterproof tape		A					
A4452	Waterproof tape		A					
A4455	Adhesive remover per ounce		A					
A4456	Adhesive remover, wipes		A					
A4458	Reusable enema bag		E					
A4461	Surgicl dress hold non-reuse		A					
A4463	Surgical dress holder reuse		A					
A4465	Non-elastic extremity binder		N					
A4466	Elastic garment/covering		E					
A4470	Graviee jet washer		N					
A4480	Vabra aspirator		N					
A4481	Tracheostoma filter		A					
A4483	Moisture exchanger		A					
A4490	Above knee surgical stocking		E					
A4495	Thigh length surg stocking		E					
A4500	Below knee surgical stocking		E					
A4510	Full length surg stocking		E					
A4520	Incontinence garment anytype		E					
A4550	Surgical trays		B					
A4554	Disposable underpads		E					
A4556	Electrodes, pair		Y					
A4557	Lead wires, pair		Y					
A4558	Conductive gel or paste		Y					
A4559	Coupling gel or paste		Y					
A4561	Pessary rubber, any type		N					
A4562	Pessary, non rubber,any type		N					
A4565	Slings		N					
A4566	Should sling/vest/abrestrain	NI	E					
A4570	Splint		E					
A4575	Hyperbaric o2 chamber disps		E					
A4580	Cast supplies (plaster)		E					
A4590	Special casting material		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4595	TENS suppl 2 lead per month		Y					
A4600	Sleeve, inter limb comp dev		Y					
A4601	Lith ion batt, non-pros use		Y					
A4604	Tubing with heating element		Y					
A4605	Trach suction cath close sys		Y					
A4606	Oxygen probe used w oximeter		A					
A4608	Transtracheal oxygen cath		Y					
A4611	Heavy duty battery		Y					
A4612	Battery cables		Y					
A4613	Battery charger		Y					
A4614	Hand-held PEFR meter		Y					
A4615	Cannula nasal		Y					
A4616	Tubing (oxygen) per foot		Y					
A4617	Mouth piece		Y					
A4618	Breathing circuits		Y					
A4619	Face tent		Y					
A4620	Variable concentration mask		Y					
A4623	Tracheostomy inner cannula		A					
A4624	Tracheal suction tube		Y					
A4625	Trach care kit for new trach		A					
A4626	Tracheostomy cleaning brush		A					
A4627	Spacer bag/reservoir		E					
A4628	Oropharyngeal suction cath		Y					
A4629	Tracheostomy care kit		A					
A4630	Repl bat t.e.n.s. own by pt		Y					
A4633	Uvl replacement bulb		Y					
A4634	Replacement bulb th lightbox		A					
A4635	Underarm crutch pad		Y					
A4636	Handgrip for cane etc		Y					
A4637	Repl tip cane/crutch/walker		Y					
A4638	Repl batt pulse gen sys		Y					
A4639	Infrared ht sys replcmnt pad		Y					
A4640	Alternating pressure pad		Y					
A4641	Radiopharm dx agent noc		N					
A4642	In111 satumomab		N					
A4648	Implantable tissue marker		N					
A4649	Surgical supplies		N					
A4650	Implant radiation dosimeter		N					
A4651	Calibrated microcap tube		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4652	Microcapillary tube sealant		A					
A4653	PD catheter anchor belt		A					
A4657	Syringe w/wo needle		N					
A4660	Sphyg/bp app w cuff and stet		N					
A4663	Dialysis blood pressure cuff		N					
A4670	Automatic bp monitor, dial		E					
A4671	Disposable cycler set		B					
A4672	Drainage ext line, dialysis		B					
A4673	Ext line w easy lock connect		B					
A4674	Chem/antisept solution, 8oz		B					
A4680	Activated carbon filter, ea		N					
A4690	Dialyzer, each		N					
A4706	Bicarbonate conc sol per gal		N					
A4707	Bicarbonate conc pow per pac		N					
A4708	Acetate conc sol per gallon		N					
A4709	Acid conc sol per gallon		N					
A4714	Treated water per gallon		N					
A4719	"Y set" tubing		N					
A4720	Dialysat sol fld vol > 249cc		N					
A4721	Dialysat sol fld vol > 999cc		N					
A4722	Dialys sol fld vol > 1999cc		N					
A4723	Dialys sol fld vol > 2999cc		N					
A4724	Dialys sol fld vol > 3999cc		N					
A4725	Dialys sol fld vol > 4999cc		N					
A4726	Dialys sol fld vol > 5999cc		N					
A4728	Dialysate solution, non-dex		B					
A4730	Fistula cannulation set, ea		N					
A4736	Topical anesthetic, per gram		N					
A4737	Inj anesthetic per 10 ml		N					
A4740	Shunt accessory		N					
A4750	Art or venous blood tubing		N					
A4755	Comb art/venous blood tubing		N					
A4760	Dialysate sol test kit, each		N					
A4765	Dialysate conc pow per pack		N					
A4766	Dialysate conc sol add 10 ml		N					
A4770	Blood collection tube/vacuum		N					
A4771	Serum clotting time tube		N					
A4772	Blood glucose test strips		N					
A4773	Occult blood test strips		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4774	Ammonia test strips		N					
A4802	Protamine sulfate per 50 mg		N					
A4860	Disposable catheter tips		N					
A4870	Plumb/elec wk hm hemo equip		N					
A4890	Repair/maint cont hemo equip		N					
A4911	Drain bag/bottle		N					
A4913	Misc dialysis supplies noc		N					
A4918	Venous pressure clamp		N					
A4927	Non-sterile gloves		N					
A4928	Surgical mask		N					
A4929	Tourniquet for dialysis, ea		N					
A4930	Sterile, gloves per pair		N					
A4931	Reusable oral thermometer		N					
A4932	Reusable rectal thermometer		E					
A5051	Pouch clsd w barr attached		A					
A5052	Clsd ostomy pouch w/o barr		A					
A5053	Clsd ostomy pouch faceplate		A					
A5054	Clsd ostomy pouch w/flange		A					
A5055	Stoma cap		A					
A5061	Pouch drainable w barrier at		A					
A5062	Drnble ostomy pouch w/o barr		A					
A5063	Drain ostomy pouch w/flange		A					
A5071	Urinary pouch w/barrier		A					
A5072	Urinary pouch w/o barrier		A					
A5073	Urinary pouch on barr w/flng		A					
A5081	Continent stoma plug		A					
A5082	Continent stoma catheter		A					
A5083	Stoma absorptive cover		A					
A5093	Ostomy accessory convex inse		A					
A5102	Bedside drain btl w/wo tube		A					
A5105	Urinary suspensory		A					
A5112	Urinary leg bag		A					
A5113	Latex leg strap		A					
A5114	Foam/fabric leg strap		A					
A5120	Skin barrier, wipe or swab		A					
A5121	Solid skin barrier 6x6		A					
A5122	Solid skin barrier 8x8		A					
A5126	Disk/foam pad +or- adhesive		A					
A5131	Appliance cleaner		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A5200	Percutaneous catheter anchor		A					
A5500	Diab shoe for density insert		Y					
A5501	Diabetic custom molded shoe		Y					
A5503	Diabetic shoe w/roller/rockr		Y					
A5504	Diabetic shoe with wedge		Y					
A5505	Diab shoe w/metatarsal bar		Y					
A5506	Diabetic shoe w/off set heel		Y					
A5507	Modification diabetic shoe		Y					
A5508	Diabetic deluxe shoe		Y					
A5510	Compression form shoe insert		E					
A5512	Multi den insert direct form		Y					
A5513	Multi den insert custom mold		Y					
A6000	Wound warming wound cover		E					
A6010	Collagen based wound filler		A					
A6011	Collagen gel/paste wound fil		A					
A6021	Collagen dressing <=16 sq in		A					
A6022	Collagen drsg>16<=48 sq in		A					
A6023	Collagen dressing >48 sq in		A					
A6024	Collagen dsg wound filler		A					
A6025	Silicone gel sheet, each		E					
A6154	Wound pouch each		A					
A6196	Alginate dressing <=16 sq in		A					
A6197	Alginate drsg >16 <=48 sq in		A					
A6198	alginate dressing > 48 sq in		A					
A6199	Alginate drsg wound filler		A					
A6203	Composite drsg <= 16 sq in		A					
A6204	Composite drsg >16<=48 sq in		A					
A6205	Composite drsg > 48 sq in		A					
A6206	Contact layer <= 16 sq in		A					
A6207	Contact layer >16<= 48 sq in		A					
A6208	Contact layer > 48 sq in		A					
A6209	Foam drsg <=16 sq in w/o bdr		A					
A6210	Foam drg >16<=48 sq in w/o b		A					
A6211	Foam drg > 48 sq in w/o brdr		A					
A6212	Foam drg <=16 sq in w/border		A					
A6213	Foam drg >16<=48 sq in w/bdr		A					
A6214	Foam drg > 48 sq in w/border		A					
A6215	Foam dressing wound filler		A					
A6216	Non-sterile gauze<=16 sq in		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6217	Non-sterile gauze>16<=48 sq		A					
A6218	Non-sterile gauze > 48 sq in		A					
A6219	Gauze <= 16 sq in w/border		A					
A6220	Gauze >16 <=48 sq in w/bordr		A					
A6221	Gauze > 48 sq in w/border		A					
A6222	Gauze <=16 in no w/sal w/o b		A					
A6223	Gauze >16<=48 no w/sal w/o b		A					
A6224	Gauze > 48 in no w/sal w/o b		A					
A6228	Gauze <= 16 sq in water/sal		A					
A6229	Gauze >16<=48 sq in watr/sal		A					
A6230	Gauze > 48 sq in water/saline		A					
A6231	Hydrogel dsg<=16 sq in		A					
A6232	Hydrogel dsg>16<=48 sq in		A					
A6233	Hydrogel dressing >48 sq in		A					
A6234	Hydrocolld drg <=16 w/o bdr		A					
A6235	Hydrocolld drg >16<=48 w/o b		A					
A6236	Hydrocolld drg > 48 in w/o b		A					
A6237	Hydrocolld drg <=16 in w/bdr		A					
A6238	Hydrocolld drg >16<=48 w/bdr		A					
A6239	Hydrocolld drg > 48 in w/bdr		A					
A6240	Hydrocolld drg filler paste		A					
A6241	Hydrocolloid drg filler dry		A					
A6242	Hydrogel drg <=16 in w/o bdr		A					
A6243	Hydrogel drg >16<=48 w/o bdr		A					
A6244	Hydrogel drg >48 in w/o bdr		A					
A6245	Hydrogel drg <= 16 in w/bdr		A					
A6246	Hydrogel drg >16<=48 in w/b		A					
A6247	Hydrogel drg > 48 sq in w/b		A					
A6248	Hydrogel drsg gel filler		A					
A6250	Skin seal protect moisturizr		A					
A6251	Absorpt drg <=16 sq in w/o b		A					
A6252	Absorpt drg >16 <=48 w/o bdr		A					
A6253	Absorpt drg > 48 sq in w/o b		A					
A6254	Absorpt drg <=16 sq in w/bdr		A					
A6255	Absorpt drg >16<=48 in w/bdr		A					
A6256	Absorpt drg > 48 sq in w/bdr		A					
A6257	Transparent film <= 16 sq in		A					
A6258	Transparent film >16<=48 in		A					
A6259	Transparent film > 48 sq in		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6260	Wound cleanser any type/size		A					
A6261	Wound filler gel/paste /oz		A					
A6262	Wound filler dry form / gram		A					
A6266	Impreg gauze no h20/sal/yard		A					
A6402	Sterile gauze <= 16 sq in		A					
A6403	Sterile gauze>16 <= 48 sq in		A					
A6404	Sterile gauze > 48 sq in		A					
A6407	Packing strips, non-impreg		A					
A6410	Sterile eye pad		A					
A6411	Non-sterile eye pad		A					
A6412	Occlusive eye patch		A					
A6413	Adhesive bandage, first-aid		E					
A6441	Pad band w>=3" <5"/yd		A					
A6442	Conform band n/s w<3"/yd		A					
A6443	Conform band n/s w>=3"<5"/yd		A					
A6444	Conform band n/s w>=5"/yd		A					
A6445	Conform band s w <3"/yd		A					
A6446	Conform band s w>=3" <5"/yd		A					
A6447	Conform band s w >=5"/yd		A					
A6448	Lt compres band <3"/yd		A					
A6449	Lt compres band >=3" <5"/yd		A					
A6450	Lt compres band >=5"/yd		A					
A6451	Mod compres band w>=3"<5"/yd		A					
A6452	High compres band w>=3"<5"yd		A					
A6453	Self-adher band w <3"/yd		A					
A6454	Self-adher band w>=3" <5"/yd		A					
A6455	Self-adher band >=5"/yd		A					
A6456	Zinc paste band w >=3"<5"/yd		A					
A6457	Tubular dressing		A					
A6501	Compres burngarment bodysuit		A					
A6502	Compres burngarment chinstrp		A					
A6503	Compres burngarment facehood		A					
A6504	Cmprsburngarment glove-wrist		A					
A6505	Cmprsburngarment glove-elbow		A					
A6506	Cmprsburngrmnt glove-axilla		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6507	Cmprs burngarment foot-knee		A					
A6508	Cmprs burngarment foot-thigh		A					
A6509	Compres burn garment jacket		A					
A6510	Compres burn garment leotard		A					
A6511	Compres burn garment panty		A					
A6512	Compres burn garment, noc		A					
A6513	Compress burn mask face/neck		B					
A6530	Compression stocking BK18-30		E					
A6531	Compression stocking BK30-40		A					
A6532	Compression stocking BK40-50		A					
A6533	Gc stocking thighlngth 18-30		E					
A6534	Gc stocking thighlngth 30-40		E					
A6535	Gc stocking thighlngth 40-50		E					
A6536	Gc stocking full lngth 18-30		E					
A6537	Gc stocking full lngth 30-40		E					
A6538	Gc stocking full lngth 40-50		E					
A6539	Gc stocking waistlngth 18-30		E					
A6540	Gc stocking waistlngth 30-40		E					
A6541	Gc stocking waistlngth 40-50		E					
A6544	Gc stocking garter belt		E					
A6545	Grad comp non-elastic BK		A					
A6549	G compression stocking		E					
A6550	Neg pres wound ther drsg set		Y					
A7000	Disposable canister for pump		Y					
A7001	Nondisposable pump canister		Y					
A7002	Tubing used w suction pump		Y					
A7003	Nebulizer administration set		Y					
A7004	Disposable nebulizer sml vol		Y					
A7005	Nondisposable nebulizer set		Y					
A7006	Filtered nebulizer admin set		Y					
A7007	Lg vol nebulizer disposable		Y					
A7008	Disposable nebulizer prefill		Y					
A7009	Nebulizer reservoir bottle		Y					
A7010	Disposable corrugated tubing		Y					
A7011	Nondispos corrugated tubing		Y					
A7012	Nebulizer water collec devic		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7013	Disposable compressor filter		Y					
A7014	Compressor nondispos filter		Y					
A7015	Aerosol mask used w nebulize		Y					
A7016	Nebulizer dome & mouthpiece		Y					
A7017	Nebulizer not used w oxygen		Y					
A7018	Water distilled w/nebulizer		Y					
A7020	Interface, cough stim device	NI	Y					
A7025	Replace chest compress vest		Y					
A7026	Replace chst cmprss sys hose		Y					
A7027	Combination oral/nasal mask		Y					
A7028	Repl oral cushion combo mask		Y					
A7029	Repl nasal pillow comb mask		Y					
A7030	CPAP full face mask		Y					
A7031	Replacement facemask interfa		Y					
A7032	Replacement nasal cushion		Y					
A7033	Replacement nasal pillows		Y					
A7034	Nasal application device		Y					
A7035	Pos airway press headgear		Y					
A7036	Pos airway press chinstrap		Y					
A7037	Pos airway pressure tubing		Y					
A7038	Pos airway pressure filter		Y					
A7039	Filter, non disposable w pap		Y					
A7040	One way chest drain valve		A					
A7041	Water seal drain container		A					
A7042	Implanted pleural catheter		N					
A7043	Vacuum drainagebottle/tubing		A					
A7044	PAP oral interface		Y					
A7045	Repl exhalation port for PAP		Y					
A7046	Repl water chamber, PAP dev		Y					
A7501	Tracheostoma valve w diaphra		A					
A7502	Replacement diaphragm/fplate		A					
A7503	HMES filter holder or cap		A					
A7504	Tracheostoma HMES filter		A					
A7505	HMES or trach valve housing		A					
A7506	HMES/trachvalve adhesivedisk		A					
A7507	Integrated filter & holder		A					
A7508	Housing & Integrated Adhesiv		A					
A7509	Heat & moisture exchange sys		A					
A7520	Trach/laryn tube non-cuffed		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7521	Trach/laryn tube cuffed		A					
A7522	Trach/laryn tube stainless		A					
A7523	Tracheostomy shower protect		A					
A7524	Tracheostoma stent/stud/bttn		A					
A7525	Tracheostomy mask		A					
A7526	Tracheostomy tube collar		A					
A7527	Trach/laryn tube plug/stop		A					
A8000	Soft protect helmet prefab		Y					
A8001	Hard protect helmet prefab		Y					
A8002	Soft protect helmet custom		Y					
A8003	Hard protect helmet custom		Y					
A8004	Repl soft interface, helmet		Y					
A9150	Misc/exper non-prescript dru		B					
A9152	Single vitamin nos		E					
A9153	Multi-vitamin nos		E					
A9155	Artificial saliva		B					
A9180	Lice treatment, topical		E					
A9270	Non-covered item or service		E					
A9273	Hot/cold h2obot/cap/col/wrap	NI	Y					
A9274	Ext amb insulin delivery sys		E					
A9275	Disp home glucose monitor		E					
A9276	Disposable sensor, CGM sys		E					
A9277	External transmitter, CGM		E					
A9278	External receiver, CGM sys		E					
A9279	Monitoring feature/deviceNOC		E					
A9280	Alert device, noc		E					
A9281	Reaching/grabbing device		E					
A9282	Wig any type		E					
A9283	Foot press off load supp dev		E					
A9284	Non-electronic spirometer		N					
A9300	Exercise equipment		E					
A9500	Tc99m sestamibi		N					
A9501	Technetium TC-99m teboroxime		N					
A9502	Tc99m tetrofosmin		N					
A9503	Tc99m medronate		N					
A9504	Tc99m apcitide		N					
A9505	TL201 thallium		N					
A9507	In111 capromab		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9508	I131 iodobenguate, dx		N					
A9509	Iodine I-123 sod iodide mil		N					
A9510	Tc99m disofenin		N					
A9512	Tc99m pertechnetate		N					
A9516	Iodine I-123 sod iodide mic		N					
A9517	I131 iodide cap, rx		K	1064	.	$17.58	.	$3.52
A9521	Tc99m exametazime		N					
A9524	I131 serum albumin, dx		N					
A9526	Nitrogen N-13 ammonia		N					
A9527	Iodine I-125 sodium iodide		U	2632	0.3143	$21.65	.	$4.33
A9528	Iodine I-131 iodide cap, dx		N					
A9529	I131 iodide sol, dx		N					
A9530	I131 iodide sol, rx		K	1150	.	$13.26	.	$2.66
A9531	I131 max 100uCi		N					
A9532	I125 serum albumin, dx		N					
A9536	Tc99m depreotide		N					
A9537	Tc99m mebrofenin		N					
A9538	Tc99m pyrophosphate		N					
A9539	Tc99m pentetate		N					
A9540	Tc99m MAA		N					
A9541	Tc99m sulfur colloid		N					
A9542	In111 ibritumomab, dx		N					
A9543	Y90 ibritumomab, rx		K	1643	.	$30,717.68	.	$6,143.54
A9544	I131 tositumomab, dx		N					
A9545	I131 tositumomab, rx		K	1645	.	$29,697.39	.	$5,939.48
A9546	Co57/58		N					
A9547	In111 oxyquinoline		N					
A9548	In111 pentetate		N					
A9550	Tc99m gluceptate		N					
A9551	Tc99m succimer		N					
A9552	F18 fdg		N					
A9553	Cr51 chromate		N					
A9554	I125 iothalamate, dx		N					
A9555	Rb82 rubidium		N					
A9556	Ga67 gallium		N					
A9557	Tc99m bicisate		N					
A9558	Xe133 xenon 10mci		N					
A9559	Co57 cyano		N					
A9560	Tc99m labeled rbc		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9561	Tc99m oxidronate		N					
A9562	Tc99m mertiatide		N					
A9563	P32 Na phosphate		K	1675	.	$162.87	.	$32.58
A9564	P32 chromic phosphate		K	1676	.	$154.15	.	$30.83
A9566	Tc99m fanolesomab		N					
A9567	Technetium TC-99m aerosol		N					
A9568	Technetium tc99m arcitumomab		N					
A9569	Technetium TC-99m auto WBC		N					
A9570	Indium In-111 auto WBC		N					
A9571	Indium IN-111 auto platelet		N					
A9572	Indium In-111 pentetreotide		N					
A9576	Inj prohance multipack		N					
A9577	Inj multihance		N					
A9578	Inj multihance multipack		N					
A9579	Gad-base MR contrast NOS,1ml		N					
A9580	Sodium fluoride F-18		N					
A9581	Gadoxetate disodium inj	CH	N					
A9582	Iodine I-123 iobenguane		G	9247	.	$2,394.59		$0.00
A9583	Gadofosveset trisodium inj		G	1299	.	$12.82		$0.00
A9600	Sr89 strontium		K	0701	.	$874.94	.	$174.99
A9604	Sm 153 lexidronam		K	1295	.	$7,484.58	.	$1,496.92
A9698	Non-rad contrast materialNOC		N					
A9699	Radiopharm rx agent noc		N					
A9700	Echocardiography Contrast		B					
A9900	Supply/accessory/service		Y					
A9901	Delivery/set up/dispensing		A					
A9999	DME supply or accessory, nos		Y					
B4034	Enter feed supkit syr by day		Y					
B4035	Enteral feed supp pump per d		Y					
B4036	Enteral feed sup kit grav by		Y					
B4081	Enteral ng tubing w/ stylet		Y					
B4082	Enteral ng tubing w/o stylet		Y					
B4083	Enteral stomach tube levine		Y					
B4087	Gastro/jejuno tube, std		A					
B4088	Gastro/jejuno tube, low-pro		A					
B4100	Food thickener oral		E					
B4102	EF adult fluids and electro		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
B4103	EF ped fluid and electrolyte		Y					
B4104	Additive for enteral formula		E					
B4149	EF blenderized foods		Y					
B4150	EF complet w/intact nutrient		Y					
B4152	EF calorie dense>/=1.5Kcal		Y					
B4153	EF hydrolyzed/amino acids		Y					
B4154	EF spec metabolic noninherit		Y					
B4155	EF incomplete/modular		Y					
B4157	EF special metabolic inherit		Y					
B4158	EF ped complete intact nut		Y					
B4159	EF ped complete soy based		Y					
B4160	EF ped caloric dense>/=0.7kc		Y					
B4161	EF ped hydrolyzed/amino acid		Y					
B4162	EF ped specmetabolic inherit		Y					
B4164	Parenteral 50% dextrose solu		Y					
B4168	Parenteral sol amino acid 3.		Y					
B4172	Parenteral sol amino acid 5.		Y					
B4176	Parenteral sol amino acid 7-		Y					
B4178	Parenteral sol amino acid >		Y					
B4180	Parenteral sol carb > 50%		Y					
B4185	Parenteral sol 10 gm lipids		B					
B4189	Parenteral sol amino acid &		Y					
B4193	Parenteral sol 52-73 gm prot		Y					
B4197	Parenteral sol 74-100 gm pro		Y					
B4199	Parenteral sol > 100gm prote		Y					
B4216	Parenteral nutrition additiv		Y					
B4220	Parenteral supply kit premix		Y					
B4222	Parenteral supply kit homemi		Y					
B4224	Parenteral administration ki		Y					
B5000	Parenteral sol renal-amirosy		Y					
B5100	Parenteral sol hepatic-fream		Y					
B5200	Parenteral sol stres-brnch c		Y					
B9000	Enter infusion pump w/o alrm		Y					
B9002	Enteral infusion pump w/ ala		Y					
B9004	Parenteral infus pump portab		Y					
B9006	Parenteral infus pump statio		Y					
B9998	Enteral supp not otherwise c		Y					
B9999	Parenteral supp not othrws c		Y					
C1300	HYPERBARIC Oxygen		S	0659	1.5244	$104.99	.	$21.00

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1713	Anchor/screw bn/bn,tis/bn		N					
C1714	Cath, trans atherectomy, dir		N					
C1715	Brachytherapy needle		N					
C1716	Brachytx, non-str, Gold-198		U	1716	2.7603	$190.12	.	$38.03
C1717	Brachytx, non-str,HDR Ir-192		U	1717	3.1777	$218.87	.	$43.78
C1719	Brachytx, NS, Non-HDRIr-192		U	1719	0.4075	$28.07	.	$5.62
C1721	AICD, dual chamber		N					
C1722	AICD, single chamber		N					
C1724	Cath, trans atherec,rotation		N					
C1725	Cath, translumin non-laser		N					
C1726	Cath, bal dil, non-vascular		N					
C1727	Cath, bal tis dis, non-vas		N					
C1728	Cath, brachytx seed adm		N					
C1729	Cath, drainage		N					
C1730	Cath, EP, 19 or few elect		N					
C1731	Cath, EP, 20 or more elec		N					
C1732	Cath, EP, diag/abl, 3D/vect		N					
C1733	Cath, EP, othr than cool-tip		N					
C1749	Endo, colon, retro imaging		H	1749	.			
C1750	Cath, hemodialysis,long-term		N					
C1751	Cath, inf, per/cent/midline		N					
C1752	Cath,hemodialysis,short-term		N					
C1753	Cath, intravas ultrasound		N					
C1754	Catheter, intradiscal		N					
C1755	Catheter, intraspinal		N					
C1756	Cath, pacing, transesoph		N					
C1757	Cath, thrombectomy/embolect		N					
C1758	Catheter, ureteral		N					
C1759	Cath, intra echocardiography		N					
C1760	Closure dev, vasc		N					
C1762	Conn tiss, human(inc fascia)		N					
C1763	Conn tiss, non-human		N					
C1764	Event recorder, cardiac		N					
C1765	Adhesion barrier		N					
C1766	Intro/sheath,strble,non-peel		N					
C1767	Generator, neuro non-recharg		N					
C1768	Graft, vascular		N					
C1769	Guide wire		N					
C1770	Imaging coil, MR, insertable		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1771	Rep dev, urinary, w/sling		N					
C1772	Infusion pump, programmable		N					
C1773	Ret dev, insertable		N					
C1776	Joint device (implantable)		N					
C1777	Lead, AICD, endo single coil		N					
C1778	Lead, neurostimulator		N					
C1779	Lead, pmkr, transvenous VDD		N					
C1780	Lens, intraocular (new tech)		N					
C1781	Mesh (implantable)		N					
C1782	Morcellator		N					
C1783	Ocular imp, aqueous drain de		N					
C1784	Ocular dev, intraop, det ret		N					
C1785	Pmkr, dual, rate-resp		N					
C1786	Pmkr, single, rate-resp		N					
C1787	Patient progr, neurostim		N					
C1788	Port, indwelling, imp		N					
C1789	Prosthesis, breast, imp		N					
C1813	Prosthesis, penile, inflatab		N					
C1814	Retinal tamp, silicone oil		N					
C1815	Pros, urinary sph, imp		N					
C1816	Receiver/transmitter, neuro		N					
C1817	Septal defect imp sys		N					
C1818	Integrated keratoprosthesis		N					
C1819	Tissue localization-excision		N					
C1820	Generator neuro rechg bat sy		N					
C1821	Interspinous implant		N					
C1874	Stent, coated/cov w/del sys		N					
C1875	Stent, coated/cov w/o del sy		N					
C1876	Stent, non-coa/non-cov w/del		N					
C1877	Stent, non-coat/cov w/o del		N					
C1878	Matrl for vocal cord		N					
C1879	Tissue marker, implantable		N					
C1880	Vena cava filter		N					
C1881	Dialysis access system		N					
C1882	AICD, other than sing/dual		N					
C1883	Adapt/ext, pacing/neuro lead		N					
C1884	Embolization Protect syst		N					
C1885	Cath, translumin angio laser		N					
C1887	Catheter, guiding		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1888	Endovas non-cardiac abl cath		N					
C1891	Infusion pump,non-prog, perm		N					
C1892	Intro/sheath,fixed,peel-away		N					
C1893	Intro/sheath, fixed,non-peel		N					
C1894	Intro/sheath, non-laser		N					
C1895	Lead, AICD, endo dual coil		N					
C1896	Lead, AICD, non sing/dual		N					
C1897	Lead, neurostim test kit		N					
C1898	Lead, pmkr, other than trans		N					
C1899	Lead, pmkr/AICD combination		N					
C1900	Lead, coronary venous		N					
C2614	Probe, perc lumb disc		N					
C2615	Sealant, pulmonary, liquid		N					
C2616	Brachytx, non-str,Yttrium-90		U	2616	240.5603	$16,568.83	.	$3,313.77
C2617	Stent, non-cor, tem w/o del		N					
C2618	Probe, cryoablation		N					
C2619	Pmkr, dual, non rate-resp		N					
C2620	Pmkr, single, non rate-resp		N					
C2621	Pmkr, other than sing/dual		N					
C2622	Prosthesis, penile, non-inf		N					
C2625	Stent, non-cor, tem w/del sy		N					
C2626	Infusion pump, non-prog,temp		N					
C2627	Cath, suprapubic/cystoscopic		N					
C2628	Catheter, occlusion		N					
C2629	Intro/sheath, laser		N					
C2630	Cath, EP, cool-tip		N					
C2631	Rep dev, urinary, w/o sling		N					
C2634	Brachytx, non-str, HA, I-125		U	2634	0.8166	$56.24	.	$11.25
C2635	Brachytx, non-str, HA, P-103		U	2635	0.4159	$28.65	.	$5.73
C2636	Brachy linear, non-str,P-103		U	2636	0.5394	$37.15	.	$7.43
C2637	Brachy,non-str,Ytterbium-169		B					
C2638	Brachytx, stranded, I-125		U	2638	0.6043	$41.62	.	$8.33
C2639	Brachytx, non-stranded,I-125		U	2639	0.5307	$36.55	.	$7.31
C2640	Brachytx, stranded, P-103		U	2640	1.0560	$72.73	.	$14.55
C2641	Brachytx, non-stranded,P-103		U	2641	0.9519	$65.56	.	$13.12
C2642	Brachytx, stranded, C-131		U	2642	1.8044	$124.28	.	$24.86
C2643	Brachytx, non-stranded,C-131		U	2643	0.9665	$66.57	.	$13.32
C2698	Brachytx, stranded, NOS		U	2698	0.6043	$41.62	.	$8.33
C2699	Brachytx, non-stranded, NOS		U	2699	0.4075	$28.07	.	$5.62

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C8900	MRA w/cont, abd		Q3	0284	6.3444	$436.98	$146.85	$87.40
C8901	MRA w/o cont, abd		Q3	0336	4.9789	$342.93	$135.13	$68.59
C8902	MRA w/o fol w/cont, abd		Q3	0337	7.7472	$533.60	$197.64	$106.72
C8903	MRI w/cont, breast, uni		Q3	0284	6.3444	$436.98	$146.85	$87.40
C8904	MRI w/o cont, breast, uni		Q3	0336	4.9789	$342.93	$135.13	$68.59
C8905	MRI w/o fol w/cont, brst, un		Q3	0337	7.7472	$533.60	$197.64	$106.72
C8906	MRI w/cont, breast, bi		Q3	0284	6.3444	$436.98	$146.85	$87.40
C8907	MRI w/o cont, breast, bi		Q3	0336	4.9789	$342.93	$135.13	$68.59
C8908	MRI w/o fol w/cont, breast,		Q3	0337	7.7472	$533.60	$197.64	$106.72
C8909	MRA w/cont, chest		Q3	0284	6.3444	$436.98	$146.85	$87.40
C8910	MRA w/o cont, chest		Q3	0336	4.9789	$342.93	$135.13	$68.59
C8911	MRA w/o fol w/cont, chest		Q3	0337	7.7472	$533.60	$197.64	$106.72
C8912	MRA w/cont, lwr ext		Q3	0284	6.3444	$436.98	$146.85	$87.40
C8913	MRA w/o cont, lwr ext		Q3	0336	4.9789	$342.93	$135.13	$68.59
C8914	MRA w/o fol w/cont, lwr ext		Q3	0337	7.7472	$533.60	$197.64	$106.72
C8918	MRA w/cont, pelvis		Q3	0284	6.3444	$436.98	$146.85	$87.40
C8919	MRA w/o cont, pelvis		Q3	0336	4.9789	$342.93	$135.13	$68.59
C8920	MRA w/o fol w/cont, pelvis		Q3	0337	7.7472	$533.60	$197.64	$106.72
C8921	TTE w or w/o fol w/cont, com		S	0128	7.2453	$499.03	$166.16	$99.81
C8922	TTE w or w/o fol w/cont, f/u		S	0128	7.2453	$499.03	$166.16	$99.81
C8923	2D TTE w or w/o fol w/con,co		S	0128	7.2453	$499.03	$166.16	$99.81
C8924	2D TTE w or w/o fol w/con,fu		S	0128	7.2453	$499.03	$166.16	$99.81
C8925	2D TEE w or w/o fol w/con,in		S	0128	7.2453	$499.03	$166.16	$99.81
C8926	TEE w or w/o fol w/cont,cong		S	0128	7.2453	$499.03	$166.16	$99.81
C8927	TEE w or w/o fol w/cont, mon		S	0128	7.2453	$499.03	$166.16	$99.81
C8928	TTE w or w/o fol w/con,stres		S	0128	7.2453	$499.03	$166.16	$99.81
C8929	TTE w or wo fol wcon,Doppler		S	0128	7.2453	$499.03	$166.16	$99.81
C8930	TTE w or w/o contr, cont ECG		S	0128	7.2453	$499.03	$166.16	$99.81
C8931	MRA, w/dye, spinal canal		Q3	0284	6.3444	$436.98	$146.85	$87.40
C8932	MRA, w/o dye, spinal canal		Q3	0336	4.9789	$342.93	$135.13	$68.59
C8933	MRA, w/o&w/dye, spinal canal		Q3	0337	7.7472	$533.60	$197.64	$106.72
C8934	MRA, w/dye, upper extremity		Q3	0284	6.3444	$436.98	$146.85	$87.40
C8935	MRA, w/o dye, upper extr		Q3	0336	4.9789	$342.93	$135.13	$68.59
C8936	MRA, w/o&w/dye, upper extr		Q3	0337	7.7472	$533.60	$197.64	$106.72
C8957	Prolonged IV inf, req pump		S	0440	2.9888	$205.86	.	$41.18
C9113	Inj pantoprazole sodium, via		N					
C9121	Injection, argatroban		K	9121	.	$19.03	.	$3.81
C9248	Inj, clevidipine butyrate	CH	K	9248	.	$2.97	.	$0.60
C9250	Artiss fibrin sealant		G	9250	.	$122.05	.	$24.18

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

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C9254	Injection, lacosamide		K	9254	.	$0.16	.	$0.04
C9255	Paliperidone palmitate inj	CH	D					
C9256	Dexamethasone intravitreal	CH	D					
C9257	Bevacizumab injection		K	1281	.	$1.45	.	$0.29
C9258	Telavancin injection	CH	D					
C9259	Pralatrexate injection	CH	D					
C9260	Ofatumumab injection	CH	D					
C9261	Ustekinumab injection	CH	D					
C9263	Ecallantide injection	CH	D					
C9264	Tocilizumab injection	CH	D					
C9265	Romidepsin injection	CH	D					
C9266	Collagenase clostridum histo	CH	D					
C9267	Injection, Wilate	CH	D					
C9268	Capsaicin patch	CH	D					
C9269	C-1 esterase, berinert	CH	D					
C9270	Gammaplex IVIG		G	9270	.	$60.42	.	$11.97
C9271	Velaglucerase alfa	CH	D					
C9272	Inj, denosumab		G	9272	.	$14.58	.	$2.89
C9273	Sipuleucel-T, per infusion		G	9273	.	$32,860.00	.	$6,510.00
C9274	Crotalidae Poly Immune Fab	NI	G	9274	.	$1,947.49	.	$385.82
C9275	Hexaminolevulinate HCl	NI	G	9275	.	$636.00		$0.00
C9276	Cabazitaxel injection	NI	G	9276	.	$141.33	.	$28.00
C9277	Lumizyme, 1 mg	NI	G	9277	.	$14.84	.	$2.94
C9278	Incobotulinumtoxin A	NI	G	9278	.	$5.57	.	$1.10
C9279	Injection, ibuprofen	NI	G	9279		$1.40		$0.28
C9352	Neuragen nerve guide, per cm		N					
C9353	Neurawrap nerve protector,cm		N					
C9354	Veritas collagen matrix, cm2		N					
C9355	Neuromatrix nerve cuff, cm		N					
C9356	TenoGlide tendon prot, cm2	CH	N					
C9358	SurgiMend, fetal	CH	K	9358	.	$10.60	.	$2.12
C9359	Implnt,bon void filler-putty	CH	N					
C9360	SurgiMend, neonatal		G	9360	.	$11.26	.	$2.23
C9361	NeuroMend nerve wrap		G	9361	.	$251.08		$0.00
C9362	Implnt,bon void filler-strip		G	9362	.	$50.09	.	$9.92
C9363	Integra Meshed Bil Wound Mat		G	9363	.	$19.56	.	$3.88
C9364	Porcine implant, Permacol		G	9364	.	$18.85		$0.00
C9367	Endoform Dermal Template		G	9367	.	$4.35	.	$0.86
C9399	Unclassified drugs or biolog		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C9716	Radiofrequency energy to anu		T	0150	32.6594	$2,249.45	.	$449.89
C9724	EPS gast cardia plic		T	0422	16.6785	$1,148.75	$280.07	$229.75
C9725	Place endorectal app		T	0148	6.0158	$414.34	.	$82.87
C9726	Rxt breast appl place/remov		T	0028	25.5910	$1,762.61	.	$352.53
C9727	Insert palate implants		T	0252	7.9194	$545.46	$109.16	$109.10
C9728	Place device/marker, non pro		X	0310	13.4552	$926.74	$325.27	$185.35
C9800	Dermal filler inj px/suppl		T	0135	4.6422	$319.74	.	$63.95
C9801	Tobacco-use counsel 3-10 min	CH	D					
C9802	Tobacco-use counsel >10min	CH	D					
C9898	Inpnt stay radiolabeled item		N					
C9899	Inpt implant pros dev,no cov		A					
D0120	Periodic oral evaluation		E					
D0140	Limit oral eval problm focus		E					
D0145	Oral evaluation, pt < 3yrs		E					
D0150	Comprehensve oral evaluation		S	0330	8.1928	$564.29	.	$112.86
D0160	Extensv oral eval prob focus		E					
D0170	Re-eval,est pt,problem focus		E					
D0180	Comp periodontal evaluation		E					
D0210	Intraor complete film series		E					
D0220	Intraoral periapical first f		E					
D0230	Intraoral periapical ea add		E					
D0240	Intraoral occlusal film		S	0330	8.1928	$564.29	.	$112.86
D0250	Extraoral first film		S	0330	8.1928	$564.29	.	$112.86
D0260	Extraoral ea additional film		S	0330	8.1928	$564.29	.	$112.86
D0270	Dental bitewing single film		S	0330	8.1928	$564.29	.	$112.86
D0272	Dental bitewings two films		S	0330	8.1928	$564.29	.	$112.86
D0273	Bitewings - three films		E					
D0274	Dental bitewings four films		S	0330	8.1928	$564.29	.	$112.86
D0277	Vert bitewings-sev to eight		S	0330	8.1928	$564.29	.	$112.86
D0290	Dental film skull/facial bon		E					
D0310	Dental sialography		E					
D0320	Dental tmj arthrogram incl i		E					
D0321	Dental other tmj films		E					
D0322	Dental tomographic survey		E					
D0330	Dental panoramic film		E					
D0340	Dental cephalometric film		E					
D0350	Oral/facial photo images		E					
D0360	Cone beam ct		E					
D0362	Cone beam, two dimensional		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D0363	Cone beam, three dimensional		E					
D0415	Collection of microorganisms		E					
D0416	Viral culture		B					
D0417	Collect & prep saliva sample		E					
D0418	Analysis of saliva sample		E					
D0421	Gen tst suscept oral disease		B					
D0425	Caries susceptibility test		E					
D0431	Diag tst detect mucos abnorm		B					
D0460	Pulp vitality test		S	0330	8.1928	$564.29	.	$112.86
D0470	Diagnostic casts		E					
D0472	Gross exam, prep & report		B					
D0473	Micro exam, prep & report		B					
D0474	Micro w exam of surg margins		B					
D0475	Decalcification procedure		B					
D0476	Spec stains for microorganis		B					
D0477	Spec stains not for microorg		B					
D0478	Immunohistochemical stains		B					
D0479	Tissue in-situ hybridization		B					
D0480	Cytopath smear prep & report		B					
D0481	Electron microscopy diagnost		B					
D0482	Direct immunofluorescence		B					
D0483	Indirect immunofluorescence		B					
D0484	Consult slides prep elsewher		B					
D0485	Consult inc prep of slides		B					
D0486	Access of transep cytol samp		E					
D0502	Other oral pathology procedu		B					
D0999	Unspecified diagnostic proce		B					
D1110	Dental prophylaxis adult		E					
D1120	Dental prophylaxis child		E					
D1203	Topical app fluoride child		E					
D1204	Topical app fluoride adult		E					
D1206	Topical fluoride varnish		E					
D1310	Nutri counsel-control caries		E					
D1320	Tobacco counseling		E					
D1330	Oral hygiene instruction		E					
D1351	Dental sealant per tooth		E					
D1352	Prev resin rest, perm tooth	NI	E					
D1510	Space maintainer fxd unilat		S	0330	8.1928	$564.29	.	$112.86
D1515	Fixed bilat space maintainer		S	0330	8.1928	$564.29	.	$112.86

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D1520	Remove unilat space maintain		S	0330	8.1928	$564.29		$112.86
D1525	Remove bilat space maintain		S	0330	8.1928	$564.29		$112.86
D1550	Recement space maintainer		S	0330	8.1928	$564.29		$112.86
D1555	Remove fix space maintainer		E					
D2140	Amalgam one surface permanen		E					
D2150	Amalgam two surfaces permane		E					
D2160	Amalgam three surfaces perma		E					
D2161	Amalgam 4 or > surfaces perm		E					
D2330	Resin one surface-anterior		E					
D2331	Resin two surfaces-anterior		E					
D2332	Resin three surfaces-anterio		E					
D2335	Resin 4/> surf or w incis an		E					
D2390	Ant resin-based cmpst crown		E					
D2391	Post 1 srfc resinbased cmpst		E					
D2392	Post 2 srfc resinbased cmpst		E					
D2393	Post 3 srfc resinbased cmpst		E					
D2394	Post >=4srfc resinbase cmpst		E					
D2410	Dental gold foil one surface		E					
D2420	Dental gold foil two surface		E					
D2430	Dental gold foil three surfa		E					
D2510	Dental inlay metalic 1 surf		E					
D2520	Dental inlay metallic 2 surf		E					
D2530	Dental inlay metl 3/more sur		E					
D2542	Dental onlay metallic 2 surf		E					
D2543	Dental onlay metallic 3 surf		E					
D2544	Dental onlay metl 4/more sur		E					
D2610	Inlay porcelain/ceramic 1 su		E					
D2620	Inlay porcelain/ceramic 2 su		E					
D2630	Dental onlay porc 3/more sur		E					
D2642	Dental onlay porcelin 2 surf		E					
D2643	Dental onlay porcelin 3 surf		E					
D2644	Dental onlay porc 4/more sur		E					
D2650	Inlay composite/resin one su		E					
D2651	Inlay composite/resin two su		E					
D2652	Dental inlay resin 3/mre sur		E					
D2662	Dental onlay resin 2 surface		E					
D2663	Dental onlay resin 3 surface		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D2664	Dental onlay resin 4/mre sur		E					
D2710	Crown resin-based indirect		E					
D2712	Crown 3/4 resin-based compos		E					
D2720	Crown resin w/ high noble me		E					
D2721	Crown resin w/ base metal		E					
D2722	Crown resin w/ noble metal		E					
D2740	Crown porcelain/ceramic subs		E					
D2750	Crown porcelain w/ h noble m		E					
D2751	Crown porcelain fused base m		E					
D2752	Crown porcelain w/ noble met		E					
D2780	Crown 3/4 cast hi noble met		E					
D2781	Crown 3/4 cast base metal		E					
D2782	Crown 3/4 cast noble metal		E					
D2783	Crown 3/4 porcelain/ceramic		E					
D2790	Crown full cast high noble m		E					
D2791	Crown full cast base metal		E					
D2792	Crown full cast noble metal		E					
D2794	Crown-titanium		E					
D2799	Provisional crown		E					
D2910	Recement inlay onlay or part		E					
D2915	Recement cast or prefab post		E					
D2920	Dental recement crown		E					
D2930	Prefab stnlss steel crwn pri		E					
D2931	Prefab stnlss steel crown pe		E					
D2932	Prefabricated resin crown		E					
D2933	Prefab stainless steel crown		E					
D2934	Prefab steel crown primary		E					
D2940	Protective restoration		E					
D2950	Core build-up incl any pins		E					
D2951	Tooth pin retention		E					
D2952	Post and core cast + crown		E					
D2953	Each addtnl cast post		E					
D2954	Prefab post/core + crown		E					
D2955	Post removal		E					
D2957	Each addtnl prefab post		E					
D2960	Laminate labial veneer		E					
D2961	Lab labial veneer resin		E					
D2962	Lab labial veneer porcelain		E					
D2970	Temp crown (fractured tooth)		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D2971	Add proc construct new crown		E					
D2975	Coping		E					
D2980	Crown repair		E					
D2999	Dental unspec restorative pr		S	0330	8.1928	$564.29	.	$112.86
D3110	Pulp cap direct		E					
D3120	Pulp cap indirect		E					
D3220	Therapeutic pulpotomy		E					
D3221	Gross pulpal debridement		E					
D3222	Part pulp for apexogenesis		E					
D3230	Pulpal therapy anterior prim		E					
D3240	Pulpal therapy posterior pri		E					
D3310	End thxpy, anterior tooth		E					
D3320	End thxpy, bicuspid tooth		E					
D3330	End thxpy, molar		E					
D3331	Non-surg tx root canal obs		E					
D3332	Incomplete endodontic tx		E					
D3333	Internal root repair		E					
D3346	Retreat root canal anterior		E					
D3347	Retreat root canal bicuspid		E					
D3348	Retreat root canal molar		E					
D3351	Apexification/recalc initial		E					
D3352	Apexification/recalc interim		E					
D3353	Apexification/recalc final		E					
D3354	Pulpal regeneration	NI	E					
D3410	Apicoect/perirad surg anter		E					
D3421	Root surgery bicuspid		E					
D3425	Root surgery molar		E					
D3426	Root surgery ea add root		E					
D3430	Retrograde filling		E					
D3450	Root amputation		E					
D3460	Endodontic endosseous implan		S	0330	8.1928	$564.29	.	$112.86
D3470	Intentional replantation		E					
D3910	Isolation- tooth w rubb dam		E					
D3920	Tooth splitting		E					
D3950	Canal prep/fitting of dowel		E					
D3999	Endodontic procedure		S	0330	8.1928	$564.29	.	$112.86
D4210	Gingivectomy/plasty per quad		E					
D4211	Gingivectomy/plasty per toot		E					
D4230	Ana crown exp 4 or> per quad		E					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D4231	Ana crown exp 1-3 per quad		E					
D4240	Gingival flap proc w/ planin		E					
D4241	Gngvl flap w rootplan 1-3 th		E					
D4245	Apically positioned flap		E					
D4249	Crown lengthen hard tissue		E					
D4260	Osseous surgery per quadrant		S	0330	8.1928	$564.29	.	$112.86
D4261	Osseous surgl-3teethperquad		E					
D4263	Bone replce graft first site		S	0330	8.1928	$564.29	.	$112.86
D4264	Bone replce graft each add		S	0330	8.1928	$564.29	.	$112.86
D4265	Bio mtrls to aid soft/os reg		E					
D4266	Guided tiss regen resorble		E					
D4267	Guided tiss regen nonresorb		E					
D4268	Surgical revision procedure		S	0330	8.1928	$564.29	.	$112.86
D4270	Pedicle soft tissue graft pr		S	0330	8.1928	$564.29	.	$112.86
D4271	Free soft tissue graft proc		S	0330	8.1928	$564.29	.	$112.86
D4273	Subepithelial tissue graft		S	0330	8.1928	$564.29	.	$112.86
D4274	Distal/proximal wedge proc		E					
D4275	Soft tissue allograft		E					
D4276	Con tissue w dble ped graft		E					
D4320	Provision splnt intracoronal		E					
D4321	Provisional splint extracoro		E					
D4341	Periodontal scaling & root		E					
D4342	Periodontal scaling 1-3teeth		E					
D4355	Full mouth debridement		S	0330	8.1928	$564.29	.	$112.86
D4381	Localized delivery antimicro		S	0330	8.1928	$564.29	.	$112.86
D4910	Periodontal maint procedures		E					
D4920	Unscheduled dressing change		E					
D4999	Unspecified periodontal proc		E					
D5110	Dentures complete maxillary		E					
D5120	Dentures complete mandible		E					
D5130	Dentures immediat maxillary		E					
D5140	Dentures immediat mandible		E					
D5211	Dentures maxill part resin		E					
D5212	Dentures mand part resin		E					
D5213	Dentures maxill part metal		E					
D5214	Dentures mandibl part metal		E					
D5225	Maxillary part denture flex		E					
D5226	Mandibular part denture flex		E					
D5281	Removable partial denture		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5410	Dentures adjust cmplt maxil		E					
D5411	Dentures adjust cmplt mand		E					
D5421	Dentures adjust part maxill		E					
D5422	Dentures adjust part mandbl		E					
D5510	Dentur repr broken compl bas		E					
D5520	Replace denture teeth complt		E					
D5610	Dentures repair resin base		E					
D5620	Rep part denture cast frame		E					
D5630	Rep partial denture clasp		E					
D5640	Replace part denture teeth		E					
D5650	Add tooth to partial denture		E					
D5660	Add clasp to partial denture		E					
D5670	Replc tth&acrlc on mtl frmwk		E					
D5671	Replc tth&acrlc mandibular		E					
D5710	Dentures rebase cmplt maxil		E					
D5711	Dentures rebase cmplt mand		E					
D5720	Dentures rebase part maxill		E					
D5721	Dentures rebase part mandbl		E					
D5730	Denture reln cmplt maxil ch		E					
D5731	Denture reln cmplt mand chr		E					
D5740	Denture reln part maxil chr		E					
D5741	Denture reln part mand chr		E					
D5750	Denture reln cmplt max lab		E					
D5751	Denture reln cmplt mand lab		E					
D5760	Denture reln part maxil lab		E					
D5761	Denture reln part mand lab		E					
D5810	Denture interm cmplt maxill		E					
D5811	Denture interm cmplt mandbl		E					
D5820	Denture interm part maxill		E					
D5821	Denture interm part mandbl		E					
D5850	Denture tiss conditn maxill		E					
D5851	Denture tiss condtin mandbl		E					
D5860	Overdenture complete		E					
D5861	Overdenture partial		E					
D5862	Precision attachment		E					
D5867	Replacement of precision att		E					
D5875	Prosthesis modification		E					
D5899	Removable prosthodontic proc		E					
D5911	Facial moulage sectional		S	0330	8.1928	$564.29	.	$112.86

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5912	Facial moulage complete		S	0330	8.1928	$564.29	.	$112.86
D5913	Nasal prosthesis		E					
D5914	Auricular prosthesis		E					
D5915	Orbital prosthesis		E					
D5916	Ocular prosthesis		E					
D5919	Facial prosthesis		E					
D5922	Nasal septal prosthesis		E					
D5923	Ocular prosthesis interim		E					
D5924	Cranial prosthesis		E					
D5925	Facial augmentation implant		E					
D5926	Replacement nasal prosthesis		E					
D5927	Auricular replacement		E					
D5928	Orbital replacement		E					
D5929	Facial replacement		E					
D5931	Surgical obturator		E					
D5932	Postsurgical obturator		E					
D5933	Refitting of obturator		E					
D5934	Mandibular flange prosthesis		E					
D5935	Mandibular denture prosth		E					
D5936	Temp obturator prosthesis		E					
D5937	Trismus appliance		E					
D5951	Feeding aid		E					
D5952	Pediatric speech aid		E					
D5953	Adult speech aid		E					
D5954	Superimposed prosthesis		E					
D5955	Palatal lift prosthesis		E					
D5958	Intraoral con def inter plt		E					
D5959	Intraoral con def mod palat		E					
D5960	Modify speech aid prosthesis		E					
D5982	Surgical stent		E					
D5983	Radiation applicator		S	0330	8.1928	$564.29	.	$112.86
D5984	Radiation shield		S	0330	8.1928	$564.29	.	$112.86
D5985	Radiation cone locator		S	0330	8.1928	$564.29	.	$112.86
D5986	Fluoride applicator		E					
D5987	Commissure splint		S	0330	8.1928	$564.29	.	$112.86
D5988	Surgical splint		E					
D5991	Topical medicament carrier		E					
D5992	Adjust max prost appliance	NI	E					
D5993	Main/clean max prosthesis	NI	E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5999	Maxillofacial prosthesis		E					
D6010	Odontics endosteal implant		E					
D6012	Endosteal implant		E					
D6040	Odontics eposteal implant		E					
D6050	Odontics transosteal implnt		E					
D6053	Implnt/abtmnt spprt remv dnt		E					
D6054	Implnt/abtmnt spprt remvprtl		E					
D6055	Implant connecting bar		E					
D6056	Prefabricated abutment		E					
D6057	Custom abutment		E					
D6058	Abutment supported crown		E					
D6059	Abutment supported mtl crown		E					
D6060	Abutment supported mtl crown		E					
D6061	Abutment supported mtl crown		E					
D6062	Abutment supported mtl crown		E					
D6063	Abutment supported mtl crown		E					
D6064	Abutment supported mtl crown		E					
D6065	Implant supported crown		E					
D6066	Implant supported mtl crown		E					
D6067	Implant supported mtl crown		E					
D6068	Abutment supported retainer		E					
D6069	Abutment supported retainer		E					
D6070	Abutment supported retainer		E					
D6071	Abutment supported retainer		E					
D6072	Abutment supported retainer		E					
D6073	Abutment supported retainer		E					
D6074	Abutment supported retainer		E					
D6075	Implant supported retainer		E					
D6076	Implant supported retainer		E					
D6077	Implant supported retainer		E					
D6078	Implnt/abut suprtd fixd dent		E					
D6079	Implnt/abut suprtd fixd dent		E					
D6080	Implant maintenance		E					
D6090	Repair implant		E					
D6091	Repl semi/precision attach		E					
D6092	Recement supp crown		E					
D6093	Recement supp part denture		E					
D6094	Abut support crown titanium		E					
D6095	Odontics repr abutment		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6100	Removal of implant		E					
D6190	Radio/surgical implant index		E					
D6194	Abut support retainer titani		E					
D6199	Implant procedure		E					
D6205	Pontic-indirect resin based		E					
D6210	Prosthodont high noble metal		E					
D6211	Bridge base metal cast		E					
D6212	Bridge noble metal cast		E					
D6214	Pontic titanium		E					
D6240	Bridge porcelain high noble		E					
D6241	Bridge porcelain base metal		E					
D6242	Bridge porcelain nobel metal		E					
D6245	Bridge porcelain/ceramic		E					
D6250	Bridge resin w/high noble		E					
D6251	Bridge resin base metal		E					
D6252	Bridge resin w/noble metal		E					
D6253	Provisional pontic		E					
D6254	Interim pontic	NI	E					
D6545	Dental retainr cast metl		E					
D6548	Porcelain/ceramic retainer		E					
D6600	Porcelain/ceramic inlay 2srf		E					
D6601	Porc/ceram inlay >= 3 surfac		E					
D6602	Cst hgh nble mtl inlay 2 srf		E					
D6603	Cst hgh nble mtl inlay >=3sr		E					
D6604	Cst bse mtl inlay 2 surfaces		E					
D6605	Cst bse mtl inlay >= 3 surfa		E					
D6606	Cast noble metal inlay 2 sur		E					
D6607	Cst noble mtl inlay >=3 surf		E					
D6608	Onlay porc/crmc 2 surfaces		E					
D6609	Onlay porc/crmc >=3 surfaces		E					
D6610	Onlay cst hgh nbl mtl 2 srfc		E					
D6611	Onlay cst hgh nbl mtl >=3srf		E					
D6612	Onlay cst base mtl 2 surface		E					
D6613	Onlay cst base mtl >=3 surfa		E					
D6614	Onlay cst nbl mtl 2 surfaces		E					
D6615	Onlay cst nbl mtl >=3 surfac		E					
D6624	Inlay titanium		E					
D6634	Onlay titanium		E					
D6710	Crown-indirect resin based		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6720	Retain crown resin w hi nble		E					
D6721	Crown resin w/base metal		E					
D6722	Crown resin w/noble metal		E					
D6740	Crown porcelain/ceramic		E					
D6750	Crown porcelain high noble		E					
D6751	Crown porcelain base metal		E					
D6752	Crown porcelain noble metal		E					
D6780	Crown 3/4 high noble metal		E					
D6781	Crown 3/4 cast based metal		E					
D6782	Crown 3/4 cast noble metal		E					
D6783	Crown 3/4 porcelain/ceramic		E					
D6790	Crown full high noble metal		E					
D6791	Crown full base metal cast		E					
D6792	Crown full noble metal cast		E					
D6793	Provisional retainer crown		E					
D6794	Crown titanium		E					
D6795	Interim retainer crown	NI	E					
D6920	Dental connector bar		S	0330	8.1928	$564.29	.	$112.86
D6930	Dental recement bridge		E					
D6940	Stress breaker		E					
D6950	Precision attachment		E					
D6970	Post & core plus retainer		E					
D6972	Prefab post & core plus reta		E					
D6973	Core build up for retainer		E					
D6975	Coping metal		E					
D6976	Each addtnl cast post		E					
D6977	Each addtl prefab post		E					
D6980	Bridge repair		E					
D6985	Pediatric partial denture fx		E					
D6999	Fixed prosthodontic proc		E					
D7111	Extraction coronal remnants		S	0330	8.1928	$564.29	.	$112.86
D7140	Extraction erupted tooth/exr		S	0330	8.1928	$564.29	.	$112.86
D7210	Rem imp tooth w mucoper flp		S	0330	8.1928	$564.29	.	$112.86
D7220	Impact tooth remov soft tiss		S	0330	8.1928	$564.29	.	$112.86
D7230	Impact tooth remov part bony		S	0330	8.1928	$564.29	.	$112.86
D7240	Impact tooth remov comp bony		S	0330	8.1928	$564.29	.	$112.86
D7241	Impact tooth rem bony w/comp		S	0330	8.1928	$564.29	.	$112.86
D7250	Tooth root removal		S	0330	8.1928	$564.29	.	$112.86
D7251	Coronectomy	NI	E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7260	Oral antral fistula closure		S	0330	8.1928	$564.29	.	$112.86
D7261	Primary closure sinus perf		S	0330	8.1928	$564.29	.	$112.86
D7270	Tooth reimplantation		E					
D7272	Tooth transplantation		E					
D7280	Exposure impact tooth orthod		E					
D7282	Mobilize erupted/malpos toot		E					
D7283	Place device impacted tooth		B					
D7285	Biopsy of oral tissue hard		E					
D7286	Biopsy of oral tissue soft		E					
D7287	Exfoliative cytolog collect		E					
D7288	Brush biopsy		B					
D7290	Repositioning of teeth		E					
D7291	Transseptal fiberotomy		S	0330	8.1928	$564.29	.	$112.86
D7292	Screw retained plate		E					
D7293	Temp anchorage dev w flap		E					
D7294	Temp anchorage dev w/o flap		E					
D7295	Bone harvest,auto graft proc	NI	E					
D7310	Alveoplasty w/ extraction		E					
D7311	Alveoloplasty w/extract 1-3		E					
D7320	Alveoplasty w/o extraction		E					
D7321	Alveoloplasty not w/extracts		B					
D7340	Vestibuloplasty ridge extens		E					
D7350	Vestibuloplasty exten graft		E					
D7410	Rad exc lesion up to 1.25 cm		E					
D7411	Excision benign lesion>1.25c		E					
D7412	Excision benign lesion compl		E					
D7413	Excision malig lesion<=1.25c		E					
D7414	Excision malig lesion>1.25cm		E					
D7415	Excision malig les complicat		E					
D7440	Malig tumor exc to 1.25 cm		E					
D7441	Malig tumor > 1.25 cm		E					
D7450	Rem odontogen cyst to 1.25cm		E					
D7451	Rem odontogen cyst > 1.25 cm		E					
D7460	Rem nonodonto cyst to 1.25cm		E					
D7461	Rem nonodonto cyst > 1.25 cm		E					
D7465	Lesion destruction		E					
D7471	Rem exostosis any site		E					
D7472	Removal of torus palatinus		E					
D7473	Remove torus mandibularis		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7485	Surg reduct osseoustuberosit		E					
D7490	Maxilla or mandible resectio		E					
D7510	I&d absc intraoral soft tiss		E					
D7511	Incision/drain abscess intra		B					
D7520	I&d abscess extraoral		E					
D7521	Incision/drain abscess extra		B					
D7530	Removal fb skin/areolar tiss		E					
D7540	Removal of fb reaction		E					
D7550	Removal of sloughed off bone		E					
D7560	Maxillary sinusotomy		E					
D7610	Maxilla open reduct simple		E					
D7620	Clsd reduct simpl maxilla fx		E					
D7630	Open red simpl mandible fx		E					
D7640	Clsd red simpl mandible fx		E					
D7650	Open red simp malar/zygom fx		E					
D7660	Clsd red simp malar/zygom fx		E					
D7670	Closd rductn splint alveolus		E					
D7671	Alveolus open reduction		E					
D7680	Reduct simple facial bone fx		E					
D7710	Maxilla open reduct compound		E					
D7720	Clsd reduct compd maxilla fx		E					
D7730	Open reduct compd mandble fx		E					
D7740	Clsd reduct compd mandble fx		E					
D7750	Open red comp malar/zygma fx		E					
D7760	Clsd red comp malar/zygma fx		E					
D7770	Open reduc compd alveolus fx		E					
D7771	Alveolus clsd reduc stbiz te		E					
D7780	Reduct compnd facial bone fx		E					
D7810	Tmj open reduct-dislocation		E					
D7820	Closed tmp manipulation		E					
D7830	Tmj manipulation under anest		E					
D7840	Removal of tmj condyle		E					
D7850	Tmj meniscectomy		E					
D7852	Tmj repair of joint disc		E					
D7854	Tmj excisn of joint membrane		E					
D7856	Tmj cutting of a muscle		E					
D7858	Tmj reconstruction		E					
D7860	Tmj cutting into joint		E					
D7865	Tmj reshaping components		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7870	Tmj aspiration joint fluid		E					
D7871	Lysis + lavage w catheters		E					
D7872	Tmj diagnostic arthroscopy		E					
D7873	Tmj arthroscopy lysis adhesn		E					
D7874	Tmj arthroscopy disc reposit		E					
D7875	Tmj arthroscopy synovectomy		E					
D7876	Tmj arthroscopy discectomy		E					
D7877	Tmj arthroscopy debridement		E					
D7880	Occlusal orthotic appliance		E					
D7899	Tmj unspecified therapy		E					
D7910	Dent sutur recent wnd to 5cm		E					
D7911	Dental suture wound to 5 cm		E					
D7912	Suture complicate wnd > 5 cm		E					
D7920	Dental skin graft		E					
D7940	Reshaping bone orthognathic		S	0330	8.1928	$564.29	.	$112.86
D7941	Bone cutting ramus closed		E					
D7943	Cutting ramus open w/graft		E					
D7944	Bone cutting segmented		E					
D7945	Bone cutting body mandible		E					
D7946	Reconstruction maxilla total		E					
D7947	Reconstruct maxilla segment		E					
D7948	Reconstruct midface no graft		E					
D7949	Reconstruct midface w/graft		E					
D7950	Mandible graft		E					
D7951	Sinus aug w bone/bone sup		E					
D7953	Bone replacement graft		E					
D7955	Repair maxillofacial defects		E					
D7960	Frenulectomy/frenectomy		E					
D7963	Frenuloplasty		E					
D7970	Excision hyperplastic tissue		E					
D7971	Excision pericoronal gingiva		E					
D7972	Surg redct fibrous tuberosit		E					
D7980	Sialolithotomy		E					
D7981	Excision of salivary gland		E					
D7982	Sialodochoplasty		E					
D7983	Closure of salivary fistula		E					
D7990	Emergency tracheotomy		E					
D7991	Dental coronoidectomy		E					
D7995	Synthetic graft facial bones		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7996	Implant mandible for augment		E					
D7997	Appliance removal		E					
D7998	Intraoral place of fix dev		E					
D7999	Oral surgery procedure		E					
D8010	Limited dental tx primary		E					
D8020	Limited dental tx transition		E					
D8030	Limited dental tx adolescent		E					
D8040	Limited dental tx adult		E					
D8050	Intercep dental tx primary		E					
D8060	Intercep dental tx transitn		E					
D8070	Compre dental tx transition		E					
D8080	Compre dental tx adolescent		E					
D8090	Compre dental tx adult		E					
D8210	Orthodontic rem appliance tx		E					
D8220	Fixed appliance therapy habt		E					
D8660	Preorthodontic tx visit		E					
D8670	Periodic orthodontc tx visit		E					
D8680	Orthodontic retention		E					
D8690	Orthodontic treatment		E					
D8691	Repair ortho appliance		E					
D8692	Replacement retainer		E					
D8693	Rebond/cement/repair retain		E					
D8999	Orthodontic procedure		E					
D9110	Tx dental pain minor proc		N					
D9120	Fix partial denture section		E					
D9210	Dent anesthesia w/o surgery		E					
D9211	Regional block anesthesia		E					
D9212	Trigeminal block anesthesia		E					
D9215	Local anesthesia		E					
D9220	General anesthesia		E					
D9221	General anesthesia ea ad 15m		E					
D9230	Analgesia		N					
D9241	Intravenous sedation		E					
D9242	IV sedation ea ad 30 m		E					
D9248	Sedation (non-iv)		N					
D9310	Dental consultation		E					
D9410	Dental house call		E					
D9420	Hospital/ASC call		E					
D9430	Office visit during hours		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D9440	Office visit after hours		E					
D9450	Case presentation tx plan		E					
D9610	Dent therapeutic drug inject		E					
D9612	Thera par drugs 2 or > admin		E					
D9630	Other drugs/medicaments		S	0330	8.1928	$564.29	.	$112.86
D9910	Dent appl desensitizing med		E					
D9911	Appl desensitizing resin		E					
D9920	Behavior management		E					
D9930	Treatment of complications		S	0330	8.1928	$564.29	.	$112.86
D9940	Dental occlusal guard		S	0330	8.1928	$564.29	.	$112.86
D9941	Fabrication athletic guard		E					
D9942	Repair/reline occlusal guard		E					
D9950	Occlusion analysis		S	0330	8.1928	$564.29	.	$112.86
D9951	Limited occlusal adjustment		S	0330	8.1928	$564.29	.	$112.86
D9952	Complete occlusal adjustment		S	0330	8.1928	$564.29	.	$112.86
D9970	Enamel microabrasion		E					
D9971	Odontoplasty 1-2 teeth		E					
D9972	Extrnl bleaching per arch		E					
D9973	Extrnl bleaching per tooth		E					
D9974	Intrnl bleaching per tooth		E					
D9999	Adjunctive procedure		E					
E0100	Cane adjust/fixed with tip		Y					
E0105	Cane adjust/fixed quad/3 pro		Y					
E0110	Crutch forearm pair		Y					
E0111	Crutch forearm each		Y					
E0112	Crutch underarm pair wood		Y					
E0113	Crutch underarm each wood		Y					
E0114	Crutch underarm pair no wood		Y					
E0116	Crutch underarm each no wood		Y					
E0117	Underarm springassist crutch		Y					
E0118	Crutch substitute		E					
E0130	Walker rigid adjust/fixed ht		Y					
E0135	Walker folding adjust/fixed		Y					
E0140	Walker w trunk support		Y					
E0141	Rigid wheeled walker adj/fix		Y					
E0143	Walker folding wheeled w/o s		Y					
E0144	Enclosed walker w rear seat		Y					
E0147	Walker variable wheel resist		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0148	Heavyduty walker no wheels		Y					
E0149	Heavy duty wheeled walker		Y					
E0153	Forearm crutch platform atta		Y					
E0154	Walker platform attachment		Y					
E0155	Walker wheel attachment,pair		Y					
E0156	Walker seat attachment		Y					
E0157	Walker crutch attachment		Y					
E0158	Walker leg extenders set of4		Y					
E0159	Brake for wheeled walker		Y					
E0160	Sitz type bath or equipment		Y					
E0161	Sitz bath/equipment w/faucet		Y					
E0162	Sitz bath chair		Y					
E0163	Commode chair with fixed arm		Y					
E0165	Commode chair with detacharm		Y					
E0167	Commode chair pail or pan		Y					
E0168	Heavyduty/wide commode chair		Y					
E0170	Commode chair electric		Y					
E0171	Commode chair non-electric		Y					
E0172	Seat lift mechanism toilet		E					
E0175	Commode chair foot rest		Y					
E0181	Press pad alternating w/ pum		Y					
E0182	Replace pump, alt press pad		Y					
E0184	Dry pressure mattress		Y					
E0185	Gel pressure mattress pad		Y					
E0186	Air pressure mattress		Y					
E0187	Water pressure mattress		Y					
E0188	Synthetic sheepskin pad		Y					
E0189	Lambswool sheepskin pad		Y					
E0190	Positioning cushion		E					
E0191	Protector heel or elbow		Y					
E0193	Powered air flotation bed		Y					
E0194	Air fluidized bed		Y					
E0196	Gel pressure mattress		Y					
E0197	Air pressure pad for mattres		Y					
E0198	Water pressure pad for mattr		Y					
E0199	Dry pressure pad for mattres		Y					
E0200	Heat lamp without stand		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0202	Phototherapy light w/ photom		Y					
E0203	Therapeutic lightbox tabletp		E					
E0205	Heat lamp with stand		Y					
E0210	Electric heat pad standard		Y					
E0215	Electric heat pad moist		Y					
E0217	Water circ heat pad w pump		Y					
E0218	Water circ cold pad w pump		Y					
E0220	Hot water bottle	CH	D					
E0221	Infrared heating pad system		Y					
E0225	Hydrocollator unit		Y					
E0230	Ice cap or collar	CH	D					
E0231	Wound warming device		E					
E0232	Warming card for NWT		E					
E0235	Paraffin bath unit portable		Y					
E0236	Pump for water circulating p		Y					
E0238	Heat pad non-electric moist	CH	D					
E0239	Hydrocollator unit portable		Y					
E0240	Bath/shower chair		E					
E0241	Bath tub wall rail		E					
E0242	Bath tub rail floor		E					
E0243	Toilet rail		E					
E0244	Toilet seat raised		E					
E0245	Tub stool or bench		E					
E0246	Transfer tub rail attachment		E					
E0247	Trans bench w/wo comm open		E					
E0248	HDtrans bench w/wo comm open		E					
E0249	Pad water circulating heat u		Y					
E0250	Hosp bed fixed ht w/ mattres		Y					
E0251	Hosp bed fixd ht w/o mattres		Y					
E0255	Hospital bed var ht w/ mattr		Y					
E0256	Hospital bed var ht w/o matt		Y					
E0260	Hosp bed semi-electr w/ matt		Y					
E0261	Hosp bed semi-electr w/o mat		Y					
E0265	Hosp bed total electr w/ mat		Y					
E0266	Hosp bed total elec w/o matt		Y					
E0270	Hospital bed institutional t		E					
E0271	Mattress innerspring		Y					
E0272	Mattress foam rubber		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0273	Bed board		E					
E0274	Over-bed table		E					
E0275	Bed pan standard		Y					
E0276	Bed pan fracture		Y					
E0277	Powered pres-redu air mattrs		Y					
E0280	Bed cradle		Y					
E0290	Hosp bed fx ht w/o rails w/m		Y					
E0291	Hosp bed fx ht w/o rail w/o		Y					
E0292	Hosp bed var ht w/o rail w/o		Y					
E0293	Hosp bed var ht w/o rail w/		Y					
E0294	Hosp bed semi-elect w/ mattr		Y					
E0295	Hosp bed semi-elect w/o matt		Y					
E0296	Hosp bed total elect w/ matt		Y					
E0297	Hosp bed total elect w/o mat		Y					
E0300	Enclosed ped crib hosp grade		Y					
E0301	HD hosp bed, 350-600 lbs		Y					
E0302	Ex hd hosp bed > 600 lbs		Y					
E0303	Hosp bed hvy dty xtra wide		Y					
E0304	Hosp bed xtra hvy dty x wide		Y					
E0305	Rails bed side half length		Y					
E0310	Rails bed side full length		Y					
E0315	Bed accessory brd/tbl/supprt		E					
E0316	Bed safety enclosure		Y					
E0325	Urinal male jug-type		Y					
E0326	Urinal female jug-type		Y					
E0328	Ped hospital bed, manual		Y					
E0329	Ped hospital bed semi/elect		Y					
E0350	Control unit bowel system		E					
E0352	Disposable pack w/bowel syst		E					
E0370	Air elevator for heel		E					
E0371	Nonpower mattress overlay		Y					
E0372	Powered air mattress overlay		Y					
E0373	Nonpowered pressure mattress		Y					
E0424	Stationary compressed gas 02		Y					
E0425	Gas system stationary compre		E					
E0430	Oxygen system gas portable		E					
E0431	Portable gaseous 02		Y					
E0433	Portable liquid oxygen sys		Y					
E0434	Portable liquid 02		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0435	Oxygen system liquid portabl		E					
E0439	Stationary liquid 02		Y					
E0440	Oxygen system liquid station		E					
E0441	Stationary O2 contents, gas		Y					
E0442	Stationary O2 contents, liq		Y					
E0443	Portable 02 contents, gas		Y					
E0444	Portable 02 contents, liquid		Y					
E0445	Oximeter non-invasive		N					
E0446	Topical Ox Deliver sys, nos	NI	E					
E0450	Vol control vent invasiv int		Y					
E0455	Oxygen tent excl croup/ped t		Y					
E0457	Chest shell		Y					
E0459	Chest wrap		Y					
E0460	Neg press vent portabl/statn		Y					
E0461	Vol control vent noninv int		Y					
E0462	Rocking bed w/ or w/o side r		Y					
E0463	Press supp vent invasive int		Y					
E0464	Press supp vent noninv int		Y					
E0470	RAD w/o backup non-inv intfc		Y					
E0471	RAD w/backup non inv intrfc		Y					
E0472	RAD w backup invasive intrfc		Y					
E0480	Percussor elect/pneum home m		Y					
E0481	Intrpulmnry percuss vent sys		E					
E0482	Cough stimulating device		Y					
E0483	Chest compression gen system		Y					
E0484	Non-elec oscillatory pep dvc		Y					
E0485	Oral device/appliance prefab		Y					
E0486	Oral device/appliance cusfab		Y					
E0487	Electronic spirometer		N					
E0500	Ippb all types		Y					
E0550	Humidif extens supple w ippb		Y					
E0555	Humidifier for use w/ regula		Y					
E0560	Humidifier supplemental w/ i		Y					
E0561	Humidifier nonheated w PAP		Y					
E0562	Humidifier heated used w PAP		Y					
E0565	Compressor air power source		Y					
E0570	Nebulizer with compression		Y					
E0571	Aerosol compressor for svneb		Y					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0572	Aerosol compressor adjust pr		Y					
E0574	Ultrasonic generator w svneb		Y					
E0575	Nebulizer ultrasonic		Y					
E0580	Nebulizer for use w/ regulat		Y					
E0585	Nebulizer w/ compressor & he		Y					
E0600	Suction pump portab hom modl		Y					
E0601	Cont airway pressure device		Y					
E0602	Manual breast pump		Y					
E0603	Electric breast pump		N					
E0604	Hosp grade elec breast pump		A					
E0605	Vaporizer room type		Y					
E0606	Drainage board postural		Y					
E0607	Blood glucose monitor home		Y					
E0610	Pacemaker monitr audible/vis		Y					
E0615	Pacemaker monitr digital/vis		Y					
E0616	Cardiac event recorder		N					
E0617	Automatic ext defibrillator		Y					
E0618	Apnea monitor		Y					
E0619	Apnea monitor w recorder		Y					
E0620	Cap bld skin piercing laser		Y					
E0621	Patient lift sling or seat		Y					
E0625	Patient lift bathroom or toi		E					
E0627	Seat lift incorp lift-chair		Y					
E0628	Seat lift for pt furn-electr		Y					
E0629	Seat lift for pt furn-non-el		Y					
E0630	Patient lift hydraulic		Y					
E0635	Patient lift electric		Y					
E0636	PT support & positioning sys		Y					
E0637	Combination sit to stand sys		E					
E0638	Standing frame sys		E					
E0639	Moveable patient lift system		E					
E0640	Fixed patient lift system		E					
E0641	Multi-position stnd fram sys		E					
E0642	Dynamic standing frame		E					
E0650	Pneuma compresor non-segment		Y					
E0651	Pneum compressor segmental		Y					
E0652	Pneum compres w/cal pressure		Y					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0655	Pneumatic appliance half arm		Y					
E0656	Segmental pneumatic trunk		Y					
E0657	Segmental pneumatic chest		Y					
E0660	Pneumatic appliance full leg		Y					
E0665	Pneumatic appliance full arm		Y					
E0666	Pneumatic appliance half leg		Y					
E0667	Seg pneumatic appl full leg		Y					
E0668	Seg pneumatic appl full arm		Y					
E0669	Seg pneumatic appli half leg		Y					
E0671	Pressure pneum appl full leg		Y					
E0672	Pressure pneum appl full arm		Y					
E0673	Pressure pneum appl half leg		Y					
E0675	Pneumatic compression device		Y					
E0676	Inter limb compress dev NOS		Y					
E0691	Uvl pnl 2 sq ft or less		Y					
E0692	Uvl sys panel 4 ft		Y					
E0693	Uvl sys panel 5 ft		Y					
E0694	Uvl md cabinet sys 6 ft		Y					
E0700	Safety equipment		E					
E0705	Transfer device		B					
E0710	Restraints any type		E					
E0720	Tens two lead		Y					
E0730	Tens four lead		Y					
E0731	Conductive garment for tens/		Y					
E0740	Incontinence treatment systm		Y					
E0744	Neuromuscular stim for scoli		Y					
E0745	Neuromuscular stim for shock		Y					
E0746	Electromyograph biofeedback		N					
E0747	Elec osteogen stim not spine		Y					
E0748	Elec osteogen stim spinal		Y					
E0749	Elec osteogen stim implanted		N					
E0755	Electronic salivary reflex s		E					
E0760	Osteogen ultrasound stimltor		Y					
E0761	Nontherm electromgntc device		E					
E0762	Trans elec jt stim dev sys		B					
E0764	Functional neuromuscularstim		Y					
E0765	Nerve stimulator for tx n&v		Y					
E0769	Electric wound treatment dev		B					
E0770	Functional electric stim NOS		Y					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0776	Iv pole		Y					
E0779	Amb infusion pump mechanical		Y					
E0780	Mech amb infusion pump <8hrs		Y					
E0781	External ambulatory infus pu		Y					
E0782	Non-programble infusion pump		N					
E0783	Programmable infusion pump		N					
E0784	Ext amb infusn pump insulin		Y					
E0785	Replacement impl pump cathet		N					
E0786	Implantable pump replacement		N					
E0791	Parenteral infusion pump sta		Y					
E0830	Ambulatory traction device		N					
E0840	Tract frame attach headboard		Y					
E0849	Cervical pneum trac equip		Y					
E0850	Traction stand free standing		Y					
E0855	Cervical traction equipment		Y					
E0856	Cervic collar w air bladder		Y					
E0860	Tract equip cervical tract		Y					
E0870	Tract frame attach footboard		Y					
E0880	Trac stand free stand extrem		Y					
E0890	Traction frame attach pelvic		Y					
E0900	Trac stand free stand pelvic		Y					
E0910	Trapeze bar attached to bed		Y					
E0911	HD trapeze bar attach to bed		Y					
E0912	HD trapeze bar free standing		Y					
E0920	Fracture frame attached to b		Y					
E0930	Fracture frame free standing		Y					
E0935	Cont pas motion exercise dev		Y					
E0936	CPM device, other than knee		E					
E0940	Trapeze bar free standing		Y					
E0941	Gravity assisted traction de		Y					
E0942	Cervical head harness/halter		Y					
E0944	Pelvic belt/harness/boot		Y					
E0945	Belt/harness extremity		Y					
E0946	Fracture frame dual w cross		Y					
E0947	Fracture frame attachmnts pe		Y					
E0948	Fracture frame attachmnts ce		Y					
E0950	Tray		Y					
E0951	Loop heel		Y					
E0952	Toe loop/holder, each		Y					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0955	Cushioned headrest		Y					
E0956	W/c lateral trunk/hip suppor		Y					
E0957	W/c medial thigh support		Y					
E0958	Whlchr att- conv 1 arm drive		Y					
E0959	Amputee adapter		B					
E0960	W/c shoulder harness/straps		Y					
E0961	Wheelchair brake extension		B					
E0966	Wheelchair head rest extensi		B					
E0967	Manual wc hand rim w project		Y					
E0968	Wheelchair commode seat		Y					
E0969	Wheelchair narrowing device		Y					
E0970	Wheelchair no. 2 footplates		E					
E0971	Wheelchair anti-tipping devi		B					
E0973	W/Ch access det adj armrest		B					
E0974	W/Ch access anti-rollback		B					
E0978	W/C acc,saf belt pelv strap		B					
E0980	Wheelchair safety vest		Y					
E0981	Seat upholstery, replacement		Y					
E0982	Back upholstery, replacement		Y					
E0983	Add pwr joystick		Y					
E0984	Add pwr tiller		Y					
E0985	W/c seat lift mechanism		Y					
E0986	Man w/c push-rim pow assist		Y					
E0990	Wheelchair elevating leg res		B					
E0992	Wheelchair solid seat insert		B					
E0994	Wheelchair arm rest		Y					
E0995	Wheelchair calf rest		B					
E1002	Pwr seat tilt		Y					
E1003	Pwr seat recline		Y					
E1004	Pwr seat recline mech		Y					
E1005	Pwr seat recline pwr		Y					
E1006	Pwr seat combo w/o shear		Y					
E1007	Pwr seat combo w/shear		Y					
E1008	Pwr seat combo pwr shear		Y					
E1009	Add mech leg elevation		Y					
E1010	Add pwr leg elevation		Y					
E1011	Ped wc modify width adjustm		Y					
E1014	Reclining back add ped w/c		Y					
E1015	Shock absorber for man w/c		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1016	Shock absorber for power w/c		Y					
E1017	HD shck absrbr for hd man wc		Y					
E1018	HD shck absrber for hd powwc		Y					
E1020	Residual limb support system		Y					
E1028	W/c manual swingaway		Y					
E1029	W/c vent tray fixed		Y					
E1030	W/c vent tray gimbaled		Y					
E1031	Rollabout chair with casters		Y					
E1035	Patient transfer system <300		Y					
E1036	Patient transfer system >300		Y					
E1037	Transport chair, ped size		Y					
E1038	Transport chair pt wt<=300lb		Y					
E1039	Transport chair pt wt >300lb		Y					
E1050	Whelchr fxd full length arms		Y					
E1060	Wheelchair detachable arms		Y					
E1070	Wheelchair detachable foot r		Y					
E1083	Hemi-wheelchair fixed arms		Y					
E1084	Hemi-wheelchair detachable a		Y					
E1085	Hemi-wheelchair fixed arms		E					
E1086	Hemi-wheelchair detachable a		E					
E1087	Wheelchair lightwt fixed arm		Y					
E1088	Wheelchair lightweight det a		Y					
E1089	Wheelchair lightwt fixed arm		E					
E1090	Wheelchair lightweight det a		E					
E1092	Wheelchair wide w/ leg rests		Y					
E1093	Wheelchair wide w/ foot rest		Y					
E1100	Whchr s-recl fxd arm leg res		Y					
E1110	Wheelchair semi-recl detach		Y					
E1130	Whlchr stand fxd arm ft rest		E					
E1140	Wheelchair standard detach a		E					
E1150	Wheelchair standard w/ leg r		Y					
E1160	Wheelchair fixed arms		Y					
E1161	Manual adult wc w tiltinspac		Y					
E1170	Whlchr ampu fxd arm leg rest		Y					
E1171	Wheelchair amputee w/o leg r		Y					
E1172	Wheelchair amputee detach ar		Y					
E1180	Wheelchair amputee w/ foot r		Y					
E1190	Wheelchair amputee w/ leg re		Y					
E1195	Wheelchair amputee heavy dut		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1200	Wheelchair amputee fixed arm		Y					
E1220	Whlchr special size/constrc		Y					
E1221	Wheelchair spec size w foot		Y					
E1222	Wheelchair spec size w/ leg		Y					
E1223	Wheelchair spec size w foot		Y					
E1224	Wheelchair spec size w/ leg		Y					
E1225	Manual semi-reclining back		Y					
E1226	Manual fully reclining back		B					
E1227	Wheelchair spec sz spec ht a		Y					
E1228	Wheelchair spec sz spec ht b		Y					
E1229	Pediatric wheelchair NOS		Y					
E1230	Power operated vehicle		Y					
E1231	Rigid ped w/c tilt-in-space		Y					
E1232	Folding ped wc tilt-in-space		Y					
E1233	Rig ped wc tltnspc w/o seat		Y					
E1234	Fld ped wc tltnspc w/o seat		Y					
E1235	Rigid ped wc adjustable		Y					
E1236	Folding ped wc adjustable		Y					
E1237	Rgd ped wc adjstabl w/o seat		Y					
E1238	Fld ped wc adjstabl w/o seat		Y					
E1239	Ped power wheelchair NOS		Y					
E1240	Whchr litwt det arm leg rest		Y					
E1250	Wheelchair lightwt fixed arm		E					
E1260	Wheelchair lightwt foot rest		E					
E1270	Wheelchair lightweight leg r		Y					
E1280	Whchr h-duty det arm leg res		Y					
E1285	Wheelchair heavy duty fixed		E					
E1290	Wheelchair hvy duty detach a		E					
E1295	Wheelchair heavy duty fixed		Y					
E1296	Wheelchair special seat heig		Y					
E1297	Wheelchair special seat dept		Y					
E1298	Wheelchair spec seat depth/w		Y					
E1300	Whirlpool portable		E					
E1310	Whirlpool non-portable		Y					
E1353	Oxygen supplies regulator		Y					
E1354	Wheeled cart, port cyl/conc		Y					
E1355	Oxygen supplies stand/rack		Y					
E1356	Batt pack/cart, port conc		Y					
E1357	Battery charger, port conc		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1358	DC power adapter, port conc		Y					
E1372	Oxy suppl heater for nebuliz		Y					
E1390	Oxygen concentrator		Y					
E1391	Oxygen concentrator, dual		Y					
E1392	Portable oxygen concentrator		Y					
E1399	Durable medical equipment mi		Y					
E1405	O2/water vapor enrich w/heat		Y					
E1406	O2/water vapor enrich w/o he		Y					
E1500	Centrifuge		A					
E1510	Kidney dialysate delivry sys		A					
E1520	Heparin infusion pump		A					
E1530	Replacement air bubble detec		A					
E1540	Replacement pressure alarm		A					
E1550	Bath conductivity meter		A					
E1560	Replace blood leak detector		A					
E1570	Adjustable chair for esrd pt		A					
E1575	Transducer protect/fld bar		A					
E1580	Unipuncture control system		A					
E1590	Hemodialysis machine		A					
E1592	Auto interm peritoneal dialy		A					
E1594	Cycler dialysis machine		A					
E1600	Deli/install chrg hemo equip		A					
E1610	Reverse osmosis h2o puri sys		A					
E1615	Deionizer H2O puri system		A					
E1620	Replacement blood pump		A					
E1625	Water softening system		A					
E1630	Reciprocating peritoneal dia		A					
E1632	Wearable artificial kidney		A					
E1634	Peritoneal dialysis clamp		B					
E1635	Compact travel hemodialyzer		A					
E1636	Sorbent cartridges per 10		A					
E1637	Hemostats for dialysis, each		A					
E1639	Dialysis scale		A					
E1699	Dialysis equipment noc		A					
E1700	Jaw motion rehab system		Y					
E1701	Repl cushions for jaw motion		Y					
E1702	Repl measr scales jaw motion		Y					
E1800	Adjust elbow ext/flex device		Y					
E1801	SPS elbow device		Y					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1802	Adjst forearm pro/sup device		Y					
E1805	Adjust wrist ext/flex device		Y					
E1806	SPS wrist device		Y					
E1810	Adjust knee ext/flex device		Y					
E1811	SPS knee device		Y					
E1812	Knee ext/flex w act res ctrl		Y					
E1815	Adjust ankle ext/flex device		Y					
E1816	SPS ankle device		Y					
E1818	SPS forearm device		Y					
E1820	Soft interface material		Y					
E1821	Replacement interface SPSD		Y					
E1825	Adjust finger ext/flex devc		Y					
E1830	Adjust toe ext/flex device		Y					
E1831	Static str toe dev ext/flex	NI	Y					
E1840	Adj shoulder ext/flex device		Y					
E1841	Static str shldr dev rom adj		Y					
E1902	AAC non-electronic board		Y					
E2000	Gastric suction pump hme mdl		Y					
E2100	Bld glucose monitor w voice		Y					
E2101	Bld glucose monitor w lance		Y					
E2120	Pulse gen sys tx endolymp fl		Y					
E2201	Man w/ch acc seat w>=20"<24"		Y					
E2202	Seat width 24-27 in		Y					
E2203	Frame depth less than 22 in		Y					
E2204	Frame depth 22 to 25 in		Y					
E2205	Manual wc accessory, handrim		Y					
E2206	Complete wheel lock assembly		Y					
E2207	Crutch and cane holder		Y					
E2208	Cylinder tank carrier		Y					
E2209	Arm trough each		Y					
E2210	Wheelchair bearings		Y					
E2211	Pneumatic propulsion tire		Y					
E2212	Pneumatic prop tire tube		Y					
E2213	Pneumatic prop tire insert		Y					
E2214	Pneumatic caster tire each		Y					
E2215	Pneumatic caster tire tube		Y					
E2216	Foam filled propulsion tire		Y					
E2217	Foam filled caster tire each		Y					
E2218	Foam propulsion tire each		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2219	Foam caster tire any size ea		Y					
E2220	Solid propulsion tire each		Y					
E2221	Solid caster tire each		Y					
E2222	Solid caster integrated whl		Y					
E2224	Propulsion whl excludes tire		Y					
E2225	Caster wheel excludes tire		Y					
E2226	Caster fork replacement only		Y					
E2227	Gear reduction drive wheel		Y					
E2228	Mwc acc, wheelchair brake		Y					
E2230	Manual standing system		E					
E2231	Solid seat support base		Y					
E2291	Planar back for ped size wc		Y					
E2292	Planar seat for ped size wc		Y					
E2293	Contour back for ped size wc		Y					
E2294	Contour seat for ped size wc		Y					
E2295	Ped dynamic seating frame		Y					
E2300	Pwr seat elevation sys		Y					
E2301	Pwr standing		Y					
E2310	Electro connect btw control		Y					
E2311	Electro connect btw 2 sys		Y					
E2312	Mini-prop remote joystick		Y					
E2313	PWC harness, expand control		Y					
E2321	Hand interface joystick		Y					
E2322	Mult mech switches		Y					
E2323	Special joystick handle		Y					
E2324	Chin cup interface		Y					
E2325	Sip and puff interface		Y					
E2326	Breath tube kit		Y					
E2327	Head control interface mech		Y					
E2328	Head/extremity control inter		Y					
E2329	Head control nonproportional		Y					
E2330	Head control proximity switc		Y					
E2331	Attendant control		Y					
E2340	W/c wdth 20-23 in seat frame		Y					
E2341	W/c wdth 24-27 in seat frame		Y					
E2342	W/c dpth 20-21 in seat frame		Y					
E2343	W/c dpth 22-25 in seat frame		Y					
E2351	Electronic SGD interface		Y					
E2360	22nf nonsealed leadacid		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2361	22nf sealed leadacid battery		Y					
E2362	Gr24 nonsealed leadacid		Y					
E2363	Gr24 sealed leadacid battery		Y					
E2364	U1nonsealed leadacid battery		Y					
E2365	U1 sealed leadacid battery		Y					
E2366	Battery charger, single mode		Y					
E2367	Battery charger, dual mode		Y					
E2368	Power wc motor replacement		Y					
E2369	Pwr wc gear box replacement		Y					
E2370	Pwr wc motor/gear box combo		Y					
E2371	Gr27 sealed leadacid battery		Y					
E2372	Gr27 non-sealed leadacid		Y					
E2373	Hand/chin ctrl spec joystick		Y					
E2374	Hand/chin ctrl std joystick		Y					
E2375	Non-expandable controller		Y					
E2376	Expandable controller, repl		Y					
E2377	Expandable controller, initl		Y					
E2381	Pneum drive wheel tire		Y					
E2382	Tube, pneum wheel drive tire		Y					
E2383	Insert, pneum wheel drive		Y					
E2384	Pneumatic caster tire		Y					
E2385	Tube, pneumatic caster tire		Y					
E2386	Foam filled drive wheel tire		Y					
E2387	Foam filled caster tire		Y					
E2388	Foam drive wheel tire		Y					
E2389	Foam caster tire		Y					
E2390	Solid drive wheel tire		Y					
E2391	Solid caster tire		Y					
E2392	Solid caster tire, integrate		Y					
E2394	Drive wheel excludes tire		Y					
E2395	Caster wheel excludes tire		Y					
E2396	Caster fork		Y					
E2397	Pwc acc, lith-based battery		Y					
E2402	Neg press wound therapy pump		Y					
E2500	SGD digitized pre-rec <=8min		Y					
E2502	SGD prerec msg >8min <=20min		Y					
E2504	SGD prerec msg>20min		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	<=40min							
E2506	SGD prerec msg > 40 min		Y					
E2508	SGD spelling phys contact		Y					
E2510	SGD w multi methods msg/accs		Y					
E2511	SGD sftwre prgrm for PC/PDA		Y					
E2512	SGD accessory, mounting sys		Y					
E2599	SGD accessory noc		Y					
E2601	Gen w/c cushion wdth < 22 in		Y					
E2602	Gen w/c cushion wdth >=22 in		Y					
E2603	Skin protect wc cus wd <22in		Y					
E2604	Skin protect wc cus wd>=22in		Y					
E2605	Position wc cush wdth <22 in		Y					
E2606	Position wc cush wdth>=22 in		Y					
E2607	Skin pro/pos wc cus wd <22in		Y					
E2608	Skin pro/pos wc cus wd>=22in		Y					
E2609	Custom fabricate w/c cushion		Y					
E2610	Powered w/c cushion		B					
E2611	Gen use back cush wdth <22in		Y					
E2612	Gen use back cush wdth>=22in		Y					
E2613	Position back cush wd <22in		Y					
E2614	Position back cush wd>=22in		Y					
E2615	Pos back post/lat wdth <22in		Y					
E2616	Pos back post/lat wdth>=22in		Y					
E2617	Custom fab w/c back cushion		Y					
E2619	Replace cover w/c seat cush		Y					
E2620	WC planar back cush wd <22in		Y					
E2621	WC planar back cush wd>=22in		Y					
E2622	Adj skin pro w/c cus wd<22in	NI	Y					
E2623	Adj skin pro wc cus wd>=22in	NI	Y					
E2624	Adj skin pro/pos cus<22in	NI	Y					
E2625	Adj skin pro/pos wc cus>=22	NI	Y					
E8000	Posterior gait trainer		E					
E8001	Upright gait trainer		E					
E8002	Anterior gait trainer		E					
G0008	Admin influenza virus vac		S	0350	0.3826	$26.35	$0.00	$0.00
G0009	Admin pneumococcal vaccine		S	0350	0.3826	$26.35	$0.00	$0.00

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0010	Admin hepatitis b vaccine		B					
G0027	Semen analysis		A					
G0101	CA screen;pelvic/breast exam		V	0604	0.7602	$52.36	$0.00	$0.00
G0102	Prostate ca screening; dre		N					
G0103	PSA screening		A					
G0104	CA screen;flexi sigmoidscope		S	0159	5.5084	$379.40	$0.00	$0.00
G0105	Colorectal scrn; hi risk ind		T	0158	8.2742	$569.89	$0.00	$0.00
G0106	Colon CA screen;barium enema		S	0157	1.2404	$85.43	.	$17.09
G0108	Diab manage trn per indiv		A					
G0109	Diab manage trn ind/group		A					
G0117	Glaucoma scrn hgh risk direc		S	0698	0.9697	$66.79	.	$13.36
G0118	Glaucoma scrn hgh risk direc		S	0230	0.6053	$41.69	.	$8.34
G0120	Colon ca scrn; barium enema		S	0157	1.2404	$85.43	.	$17.09
G0121	Colon ca scrn not hi rsk ind		T	0158	8.2742	$569.89	$0.00	$0.00
G0122	Colon ca scrn; barium enema		E					
G0123	Screen cerv/vag thin layer		A					
G0124	Screen c/v thin layer by MD		B					
G0127	Trim nail(s)		T	0012	0.4326	$29.80	.	$5.96
G0128	CORF skilled nursing service		B					
G0129	Partial hosp prog service		P					
G0130	Single energy x-ray study		X	0260	0.6539	$45.04	$0.00	$0.00
G0141	Scr c/v cyto,autosys and md		B					
G0143	Scr c/v cyto,thinlayer,rescr		A					
G0144	Scr c/v cyto,thinlayer,rescr		A					
G0145	Scr c/v cyto,thinlayer,rescr		A					
G0147	Scr c/v cyto, automated sys		A					
G0148	Scr c/v cyto, autosys, rescr		A					
G0151	HHCP-serv of pt,ea 15 min		B					
G0152	HHCP-serv of ot,ea 15 min		B					
G0153	HHCP-svs of s/l path,ea 15mn		B					
G0154	HHCP-svs of rn,ea 15 min		B					
G0155	HHCP-svs of csw,ea 15 min		B					
G0156	HHCP-svs of aide,ea 15 min		B					
G0157	HHC PT assistant ea 15	NI	B					
G0158	HHC OT assistant ea 15	NI	B					
G0159	HHC PT maint ea 15 min	NI	B					
G0160	HHC Occup Therapy ea 15	NI	B					
G0161	HHC SLP ea 15 min	NI	B					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0162	HHC RN E&M plan svs, 15 min	NI	B					
G0163	HHC LPN/RN obs/asses ea 15	NI	B					
G0164	HHC lis nurse train ea 15	NI	B					
G0166	Extrnl counterpulse, per tx		T	0678	1.4754	$101.62	.	$20.33
G0168	Wound closure by adhesive		B					
G0173	Linear acc stereo radsur com		S	0067	49.4903	$3,408.69	.	$681.74
G0175	OPPS Service,sched team conf		V	0607	1.8654	$128.48	.	$25.70
G0176	OPPS/PHP;activity therapy		P					
G0177	OPPS/PHP; train & educ serv		N					
G0179	MD recertification HHA PT		M					
G0180	MD certification HHA patient		M					
G0181	Home health care supervision		M					
G0182	Hospice care supervision		M					
G0186	Dstry eye lesn,fdr vssl tech		T	0235	5.8452	$402.59	.	$80.52
G0202	Screeningmammographydigital		A					
G0204	Diagnosticmammographydigital		A					
G0206	Diagnosticmammographydigital		A					
G0219	PET img wholbod melano nonco		E					
G0235	PET not otherwise specified		E					
G0237	Therapeutic procd strg endur		S	0077	0.4171	$28.73	$7.74	$5.75
G0238	Oth resp proc, indiv		S	0077	0.4171	$28.73	$7.74	$5.75
G0239	Oth resp proc, group		S	0077	0.4171	$28.73	$7.74	$5.75
G0245	Initial foot exam pt lops		V	0604	0.7602	$52.36	.	$10.48
G0246	Followup eval of foot pt lop		V	0605	1.0908	$75.13	.	$15.03
G0247	Routine footcare pt w lops		T	0013	0.9103	$62.70	.	$12.54
G0248	Demonstrate use home inr mon		V	0607	1.8654	$128.48	.	$25.70
G0249	Provide INR test mater/equip		V	0607	1.8654	$128.48	.	$25.70
G0250	MD INR test revie inter mgmt		M					
G0251	Linear acc based stero radio		S	0065	14.1866	$977.12	.	$195.43
G0252	PET imaging initial dx		E					
G0255	Current percep threshold tst		E					
G0257	Unsched dialysis ESRD pt hos		S	0170	6.9317	$477.43	.	$95.49
G0259	Inject for sacroiliac joint		N					
G0260	Inj for sacroiliac jt anesth		T	0207	7.5886	$522.67	.	$104.54
G0268	Removal of impacted wax md		N					
G0269	Occlusive device in vein art		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0270	MNT subs tx for change dx		A					
G0271	Group MNT 2 or more 30 mins		A					
G0275	Renal angio, cardiac cath		N					
G0278	Iliac art angio,cardiac cath		N					
G0281	Elec stim unattend for press		A					
G0282	Elect stim wound care not pd		E					
G0283	Elec stim other than wound		A					
G0288	Recon, CTA for surg plan		N					
G0289	Arthro, loose body + chondro		N					
G0290	Drug-eluting stents, single		T	0656	105.6783	$7,278.70	.	$1,455.74
G0291	Drug-eluting stents,each add		T	0656	105.6783	$7,278.70	.	$1,455.74
G0293	Non-cov surg proc,clin trial		X	0340	0.6712	$46.23	.	$9.25
G0294	Non-cov proc, clinical trial		X	0340	0.6712	$46.23	.	$9.25
G0295	Electromagnetic therapy onc		E					
G0302	Pre-op service LVRS complete		S	0209	11.3359	$780.77	$268.73	$156.16
G0303	Pre-op service LVRS 10-15dos		S	0209	11.3359	$780.77	$268.73	$156.16
G0304	Pre-op service LVRS 1-9 dos		S	0213	2.4194	$166.64	$53.58	$33.33
G0305	Post op service LVRS min 6		S	0213	2.4194	$166.64	$53.58	$33.33
G0306	CBC/diffwbc w/o platelet		A					
G0307	CBC without platelet		A					
G0328	Fecal blood scrn immunoassay		A					
G0329	Electromagntic tx for ulcers		A					
G0333	Dispense fee initial 30 day		M					
G0337	Hospice evaluation preelecti		B					
G0339	Robot lin-radsurg com, first		S	0067	49.4903	$3,408.69	.	$681.74
G0340	Robt lin-radsurg fractx 2-5		S	0066	36.3649	$2,504.67	.	$500.94
G0341	Percutaneous islet celltrans		C					
G0342	Laparoscopy islet cell trans		C					
G0343	Laparotomy islet cell transp		C					
G0364	Bone marrow aspirate &biopsy		X	0340	0.6712	$46.23	.	$9.25
G0365	Vessel mapping hemo access		S	0267	2.2212	$152.99	$59.84	$30.60
G0372	MD service required for PMD		M					
G0378	Hospital observation per hr		N					
G0379	Direct refer hospital observ		Q3	0604	0.7602	$52.36	.	$10.48
G0380	Lev 1 hosp type B ED visit		V	0626	0.6005	$41.36	.	$8.28
G0381	Lev 2 hosp type B ED visit		V	0627	0.8599	$59.23	.	$11.85
G0382	Lev 3 hosp type B ED visit		V	0628	1.4740	$101.52	.	$20.31
G0383	Lev 4 hosp type B ED visit		V	0629	2.4026	$165.48	.	$33.10
G0384	Lev 5 hosp type B ED visit		Q3	0630	3.9671	$273.24	.	$54.65

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0389	Ultrasound exam AAA screen		S	0266	1.3979	$96.28	$0.00	$0.00
G0390	Trauma Respons w/hosp criti		S	0618	13.4224	$924.48	.	$184.90
G0396	Alcohol/subs interv 15-30mn		S	0432	0.4795	$33.03	.	$6.61
G0397	Alcohol/subs interv >30 min		S	0432	0.4795	$33.03	.	$6.61
G0398	Home sleep test/type 2 Porta		S	0213	2.4194	$166.64	$53.58	$33.33
G0399	Home sleep test/type 3 Porta		S	0213	2.4194	$166.64	$53.58	$33.33
G0400	Home sleep test/type 4 Porta		S	0213	2.4194	$166.64	$53.58	$33.33
G0402	Initial preventive exam		V	0606	1.4477	$99.71	$0.00	$0.00
G0403	EKG for initial prevent exam		M					
G0404	EKG tracing for initial prev		S	0099	0.3958	$27.26	.	$5.46
G0405	EKG interpret & report preve		B					
G0406	Telhealth inpt consult 15min		C					
G0407	Telheath inpt consult 25min		C					
G0408	Telhealth inpt consult 35min		C					
G0409	CORF related serv 15 mins ea		M					
G0410	Grp psych partial hosp 45-50		P					
G0411	Inter active grp psych parti		P					
G0412	Open tx iliac spine uni/bil		C					
G0413	Pelvic ring fracture uni/bil		T	0050	32.2439	$2,220.83	.	$444.17
G0414	Pelvic ring fx treat int fix		C					
G0415	Open tx post pelvic fxcture		C					
G0416	Sat biopsy prostate 1-20 spc	CH	X	0661	2.1892	$150.78	.	$30.16
G0417	Sat biopsy prostate 21-40	CH	S	1506	.	$450.00	.	$90.00
G0418	Sat biopsy prostate 41-60		S	1511	.	$950.00	.	$190.00
G0419	Sat biopsy prostate: >60		S	1513	.	$1,150.00	.	$230.00
G0420	Ed svc CKD ind per session		A					
G0421	Ed svc CKD grp per session		A					
G0422	Intens cardiac rehab w/exerc		S	0095	0.9991	$68.81	$13.86	$13.77
G0423	Intens cardiac rehab no exer		S	0095	0.9991	$68.81	$13.86	$13.77
G0424	Pulmonary rehab w exer		S	0102	0.9144	$62.98	.	$12.60
G0425	Inpt telehealth consult 30m		C					
G0426	Inpt telehealth consult 50m		C					
G0427	Inpt telehealth con 70/>m		C					
G0428	Collagen Meniscus Implant		E					
G0429	Dermal filler injection(s)		B					
G0430	Drug screen multi class	CH	D					
G0431	Drug screen multip class		A					
G0432	EIA HIV-1/HIV-2 screen		A					
G0433	ELISA HIV-1/HIV-2 screen		A					

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G0434	Drug screen multi drug class	NI	A					
G0435	Oral HIV-1/HIV-2 screen		A					
G0436	Tobacco-use counsel 3-10 min	NI	X	0031	0.3010	$20.73	$0.00	$0.00
G0437	Tobacco-use counsel>10min	NI	X	0031	0.3010	$20.73	$0.00	$0.00
G0438	PPPS, initial visit	NI	A					
G0439	PPPS, subseq visit	NI	A					
G0440	Skin/dermal subs init 25or<	NI	B					
G0441	Skin/dermal subs each addition	NI	B					
G3001	Admin + supply, tositumomab		S	0442	32.5110	$2,239.23	.	$447.85
G8006	AMI pt recd aspirin at arriv	CH	D					
G8007	AMI pt did not receiv aspiri	CH	D					
G8008	AMI pt ineligible for aspiri	CH	D					
G8009	AMI pt recd Bblock at arr	CH	D					
G8010	AMI pt did not rec bblock	CH	D					
G8011	AMI pt inelig Bbloc at arriv	CH	D					
G8012	Pneum pt recv antibiotic 4 h	CH	D					
G8013	Pneum pt w/o antibiotic 4 hr	CH	D					
G8014	Pneum pt not elig antibiotic	CH	D					
G8015	Diabetic pt w/ HBA1c>9%	CH	D					
G8016	Diabetic pt w/ HBA1c<or=9%	CH	D					
G8017	DM pt inelig for HBA1c measu	CH	D					
G8018	Care not provided for HbA1c	CH	D					
G8019	Diabetic pt w/LDL>= 100mg/dl	CH	D					
G8020	Diab pt w/LDL< 100mg/dl	CH	D					
G8021	Diab pt inelig for LDL meas	CH	D					
G8022	Care not provided for LDL	CH	D					
G8023	DM pt w BP>=140/80	CH	D					
G8024	Diabetic pt wBP<140/80	CH	D					
G8025	Diabetic pt inelig for BP me	CH	D					
G8026	Diabet pt w no care re BP me	CH	D					
G8027	HF p w/LVSD on ACE-I/ARB	CH	D					
G8028	HF pt w/LVSD not on ACE-I/AR	CH	D					
G8029	HF pt not elig for ACE-I/ARB	CH	D					
G8030	HF pt w/LVSD on Bblocker	CH	D					
G8031	HF pt w/LVSD not on Bblocker	CH	D					
G8032	HF pt not elig for Bblocker	CH	D					
G8033	PMI-CAD pt on Bblocker	CH	D					
G8034	PMI-CAD pt not on Bblocker	CH	D					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8035	PMI-CAD pt inelig Bblocker	CH	D					
G8036	AMI-CAD pt doc on antiplatel	CH	D					
G8037	AMI-CAD pt not docu on antip	CH	D					
G8038	AMI-CAD inelig antiplate mea	CH	D					
G8039	CAD pt w/LDL>100mg/dl	CH	D					
G8040	CAD pt w/LDL<or=100mg/dl	CH	D					
G8041	CAD pt not eligible for LDL	CH	D					
G8051	Osteoporosis assess	CH	D					
G8052	Osteopor pt not assess	CH	D					
G8053	Pt inelig for osteopor meas	CH	D					
G8054	Falls assess not docum 12 mo	CH	D					
G8055	Falls assess w/ 12 mon	CH	D					
G8056	Not elig for falls assessmen	CH	D					
G8057	Hearing assess receive	CH	D					
G8058	Pt w/o hearing assess	CH	D					
G8059	Pt inelig for hearing assess	CH	D					
G8060	Urinary incont pt assess	CH	D					
G8061	Pt not assess for urinary in	CH	D					
G8062	Pt not elig for urinary inco	CH	D					
G8075	ESRD pt w/ dialy of URR>=65%	CH	D					
G8076	ESRD pt w/ dialy of URR<65%	CH	D					
G8077	ESRD pt not elig for URR/KtV	CH	D					
G8078	ESRD pt w/Hct>or=33	CH	D					
G8079	ESRD pt w/Hct<33	CH	D					
G8080	ESRD pt inelig for HCT/Hgb	CH	D					
G8081	ESRD pt w/ auto AV fistula	CH	D					
G8082	ESRD pt w other fistula	CH	D					
G8085	ESRD PT inelig auto AV FISTU	CH	D					
G8093	COPD pt rec smoking cessat	CH	D					
G8094	COPD pt w/o smoke cessat int	CH	D					
G8099	Osteopo pt given Ca+VitD sup	CH	D					
G8100	Osteop pt inelig for Ca+VitD	CH	D					
G8103	New dx osteo pt w/antiresorp	CH	D					
G8104	Osteo pt inelig for antireso	CH	D					
G8106	Bone dens meas test perf	CH	D					
G8107	Bone dens meas test inelig	CH	D					
G8108	Pt receiv influenza vacc	CH	D					
G8109	Pt w/o influenza vacc	CH	D					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8110	Pt inelig for influenza vacc	CH	D					
G8111	Pt receiv mammogram	CH	D					
G8112	Pt not doc mammogram	CH	D					
G8113	Pt ineligible mammography	CH	D					
G8114	Care not provided for mamogr	CH	D					
G8115	Pt receiv pneumo vacc	CH	D					
G8116	Pt did not rec pneumo vacc	CH	D					
G8117	Pt was inelig for pneumo vac	CH	D					
G8126	Pt treat w/antidepress12wks		M					
G8127	Pt not treat w/antidepres12w		M					
G8128	Pt inelig for antidepres med		M					
G8129	Pt treat w/antidepres for 6m	CH	D					
G8130	Pt not treat w/antidepres 6m	CH	D					
G8131	Pt inelig for antidepres med	CH	D					
G8152	Pt w/AB 1 hr prior to incisi	CH	D					
G8153	Pt not doc for AB 1 hr prior	CH	D					
G8154	Pt ineligi for AB therapy	CH	D					
G8155	Pt recd thromboemb prophylax	CH	D					
G8156	Pt did not rec thromboembo	CH	D					
G8157	Pt ineligi for thrombolism	CH	D					
G8159	Pt w/CABG w/o IMA	CH	D					
G8162	Iso CABG pt w/o preop Bblock	CH	D					
G8164	Iso CABG pt w/prolng intub	CH	D					
G8165	Iso CABG pt w/o prolng intub	CH	D					
G8166	Iso CABG req surg rexpo	CH	D					
G8167	Iso CABG w/o surg explo	CH	D					
G8170	CEA/ext bypass pt on aspirin	CH	D					
G8171	Pt w/carot endarct/ext bypas	CH	D					
G8172	CEA/ext bypass pt not on asp	CH	D					
G8182	CAD pt care not prov LDL	CH	D					
G8183	HF/atrial fib pt on warfarin	CH	D					
G8184	HF/atrial fib pt inelig warf	CH	D					
G8185	Osteoarth pt w/ assess pain	CH	D					
G8186	Osteoarth pt inelig assess	CH	D					
G8193	Antibio not doc prior surg	CH	D					
G8196	Antibio not docum prior surg	CH	D					
G8200	Cefazolin not docum prophy	CH	D					
G8204	MD not doc order to d/c anti	CH	D					
G8209	Clinician did not doc	CH	D					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8214	Clini not doc order VTE	CH	D					
G8217	Pt not received DVT proph	CH	D					
G8219	Received DVT proph day 2	CH	D					
G8220	Pt not rec DVT proph day 2	CH	D					
G8221	Pt inelig for DVT proph	CH	D					
G8223	Pt not doc for presc antipla	CH	D					
G8226	Pt no prescr anticoa at D/C	CH	D					
G8231	Pt not doc for admin t-PA	CH	D					
G8234	Pt not doc dysphagia screen	CH	D					
G8238	Pt not doc to rec rehab serv	CH	D					
G8240	Inter carotid stenosis30-99%	CH	D					
G8243	Pt not doc MRI/CT w/o lesion	CH	D					
G8246	Pt inelig hx w new/chg mole	CH	D					
G8248	Pt w/one alarm symp not doc	CH	D					
G8251	Pt not doc w/Barretts, endo	CH	D					
G8254	Pt w/no doc order for barium	CH	D					
G8257	Pt not doc rev meds D/C	CH	D					
G8260	Pt not doc to have dec maker	CH	D					
G8263	Pt not doc assess urinary in	CH	D					
G8266	Pt not doc charc urin incon	CH	D					
G8268	Pt not doc rec care urin inc	CH	D					
G8271	Pt no doc screen fall	CH	D					
G8274	Clini not doc pres/abs alarm	CH	D					
G8276	Pt not doc mole change	CH	D					
G8279	Pt not doc rec PE	CH	D					
G8282	Pt not doc to rec couns	CH	D					
G8285	Pt did not rec pres osteo	CH	D					
G8289	Pt not doc rec Ca/Vit D	CH	D					
G8293	COPD pt w/o spir results	CH	D					
G8296	COPD pt not doc bronch ther	CH	D					
G8298	Pt doc optic nerve eval	CH	D					
G8299	Pt not doc optic nerv eval	CH	D					
G8302	Pt doc w/ target IOP	CH	D					
G8303	Pt not doc w/ IOP	CH	D					
G8304	Clin doc pt inelig IOP	CH	D					
G8305	Clin not prov care POAG	CH	D					
G8306	POAG w/ IOP rec care plan	CH	D					
G8307	POAG w/ IOP no care plan	CH	D					
G8308	POAG w/ IOP not doc plan	CH	D					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8310	Pt not doc rec antiox	CH	D					
G8314	Pt not doc to rec mac exam	CH	D					
G8318	Pt doc not have visual func	CH	D					
G8322	Pt not doc pre axial leng	CH	D					
G8326	Pt not doc rec fundus exam	CH	D					
G8330	Pt not doc rec dilated mac	CH	D					
G8334	Doc of macular not giv MD	CH	D					
G8338	Clin not doc pt test osteo	CH	D					
G8341	Pt not doc for DEXA	CH	D					
G8345	Pt not doc have DEXA	CH	D					
G8351	Pt not doc ECG	CH	D					
G8354	Pt not rec aspirin prior ER	CH	D					
G8357	Pt not doc to have ECG	CH	D					
G8360	Pt not doc vital signs recor	CH	D					
G8362	Pt not doc 02 SAT assess	CH	D					
G8365	Pt not doc mental status	CH	D					
G8367	Pt not doc have empiric AB	CH	D					
G8370	Asthma pt w survey not docum	CH	D					
G8371	Chemother not rec stg3 colon	CH	D					
G8372	Chemother rec stg3 colon ca	CH	D					
G8373	Chemo plan documen prior che	CH	D					
G8374	Chemo plan not doc prior che	CH	D					
G8375	CLL pt w/o doc flow cytometr	CH	D					
G8376	Brst ca pt inelig tamoxifen	CH	D					
G8377	MD doc colon ca pt inelig ch	CH	D					
G8378	MD doc pt inelig radiation	CH	D					
G8379	Doc radiat tx recom 12mo ov	CH	D					
G8380	Pt w stgIC-3Brst ca not rec	CH	D					
G8381	Pt w stgIC-3Brst ca rec tam	CH	D					
G8382	MM pt w/o doc IV bisphophon	CH	D					
G8383	No doc radiation rec 12mo ov	CH	D					
G8384	Base cytogen test MDS notper	CH	D					
G8385	Diabet pt no do Hgb A1c 12m	CH	D					
G8386	Diabet pt nodoc LDLiprotei	CH	D					
G8387	ESRD pt w Hct/Hgb not docume	CH	D					
G8388	ESRD pt w URR/Ktv notdoc eli	CH	D					
G8389	MDS pt no doc FE st prio EPO	CH	D					
G8390	Diabetic w/o document BP 12m	CH	D					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8391	Pt w asthma no doc med or tx	CH	D					
G8395	LVEF>=40% doc normal or mild		M					
G8396	LVEF not performed		M					
G8397	Dil macula/fundus exam/w doc		M					
G8398	Dil macular/fundus not perfo		M					
G8399	Pt w/DXA document or order		M					
G8400	Pt w/DXA no document or orde		M					
G8401	Pt inelig osteo screen measu		M					
G8402	Smoke preven interven counse	CH	D					
G8403	Smoke preven nocounsel	CH	D					
G8404	Low extemity neur exam docum		M					
G8405	Low extemity neur not perfor		M					
G8406	Pt inelig lower extrem neuro		M					
G8407	ABI documented	CH	D					
G8408	ABI not documented	CH	D					
G8409	Pt inelig for ABI measure	CH	D					
G8410	Eval on foot documented		M					
G8415	Eval on foot not performed		M					
G8416	Pt inelig footwear evaluatio		M					
G8417	Calc BMI abv up param f/u		M					
G8418	Calc BMI blw low param f/u		M					
G8419	Calc BMI out nrm param nof/u		M					
G8420	Calc BMI norm parameters		M					
G8421	BMI not calculated		M					
G8422	Pt inelig BMI calculation		M					
G8423	Pt screen flu vac & counsel	CH	D					
G8424	Flu vaccine not screen	CH	D					
G8425	Flu vaccine screen not curre	CH	D					
G8426	Pt not approp screen & counc	CH	D					
G8427	Doc cur meds by prov		M					
G8428	Cur meds not document		M					
G8429	Incomplete doc pt on meds	CH	D					
G8430	Pt inelig med check		M					
G8431	Pos clin depres scrn f/u doc		M					
G8432	Clin depression screen not d		M					
G8433	Pt inelig; scrn clin dep		M					
G8434	Cognitive impairment screen	CH	D					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8435	Cognitive screen not documen	CH	D					
G8436	Pt inelig for cognitive impa	CH	D					
G8437	Care plan develop & document	CH	D					
G8438	Pt inelig for devlp care pln	CH	D					
G8439	Care plan develp & not docum	CH	D					
G8440	Pain assess f/u pln document		M					
G8441	No document of pain assess		M					
G8442	Pt inelig pain assessment		M					
G8443	Prescription by E-Prescrib s	CH	D					
G8445	Prescrip not gen at encounte	CH	D					
G8446	Some prescrib print or call	CH	D					
G8447	Pt vis doc use EHR cer ATCB		M					
G8448	Pt vis doc w/PQRI qual EHR		M					
G8449	Pt not doc w/EMR due to syst	CH	D					
G8450	Beta-bloc rx pt w/abn lvef		M					
G8451	Pt w/abn lvef inelig b-bloc		M					
G8452	Pt w/abn lvef b-bloc no rx		M					
G8453	Tob use cess int counsel	CH	D					
G8454	Tob use cess int no counsel	CH	D					
G8455	Current tobacco smoker	CH	D					
G8456	Current smkless tobacco user	CH	D					
G8457	Cur tobacco non-user	CH	D					
G8458	Pt inelig geno no antvir tx		M					
G8459	Doc pt rec antivir treat		M					
G8460	Pt inelig RNA no antvir tx		M					
G8461	Pt rec antivir treat hep c		M					
G8462	Pt inelig couns no antvir tx		M					
G8463	Pt rec antiviral treat doc		M					
G8464	Pt inelig; lo to no dter rsk		M					
G8465	High risk recurrence pro ca		M					
G8466	Pt inelig suic; MDD remis	CH	D					
G8467	New dx init/rec episode MDD	CH	D					
G8468	ACE/ARB rx pt w/abn lvef		M					
G8469	Pt w/abn lvef inelig ACE/ARB		M					
G8470	Pt w/ normal lvef		M					
G8471	LVEF not performed/doc		M					
G8472	ACE/ARB no rx pt w/abn lvef		M					
G8473	ACE/ARB thxpy rx'd		M					
G8474	ACE/ARB not rx'd; doc reas		M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8475	ACE/ARB thxpy not rx'd		M					
G8476	BP sys <130 and dias <80		M					
G8477	BP sys>=130 and/or dias >=80		M					
G8478	BP not performed/doc		M					
G8479	MD rx'd ACE/ARB thxpy	CH	D					
G8480	Pt inelig ACE/ARB thxpy	CH	D					
G8481	MD not rx'd ACE/ARB thxpy	CH	D					
G8482	Flu immunize order/admin		M					
G8483	Flu imm no ord/admin doc rea		M					
G8484	Flu immunize no order/admin		M					
G8485	Report, Diabetes measures		M					
G8486	Report, Prev Care Measures		M					
G8487	Report CKD Measures		M					
G8488	Report ESRD Measures	CH	D					
G8489	CAD measures grp		M					
G8490	RA measures grp		M					
G8491	HIV/AIDS measures grp		M					
G8492	Periop Care measures grp		M					
G8493	Back pain measures grp		M					
G8494	DM meas qual act perform		M					
G8495	CKD meas qual act perform		M					
G8496	Prev Care MG qual act perfrm		M					
G8497	CABG meas qual act perform		M					
G8498	CAD meas qual act perform		M					
G8499	RA meas qual act perform		M					
G8500	HIV meas qual act perform		M					
G8501	Perio meas qual act perform		M					
G8502	Back Pain MG qual act perfrm		M					
G8506	Pt rec ACE/ARB		M					
G8507	Pt inelig pt verif meds	CH	D					
G8508	Pt inelig; pain asses no f/u		M					
G8509	Pain assess no f/u pln doc		M					
G8510	Pt inelig neg scrn depres		M					
G8511	Clin depres scrn no f/u doc		M					
G8518	Clin stg b/f lun/eso ca surg	CH	D					
G8519	Pt in; clin ca stg b/f surg	CH	D					
G8520	Clin stg b/f surg not doc	CH	D					
G8524	Patch closure conv CEA		M					
G8525	No patch closure CEA		M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8526	No patch closure conv CEA		M					
G8530	Auto AV fistula recd		M					
G8531	Pt inelig; auto AV fistula		M					
G8532	No auto AV fistula; no reas		M					
G8534	Doc elder mal scrn f/u plan		M					
G8535	Pt inelig no eld mal scrn		M					
G8536	No doc elder mal scrn		M					
G8537	Pt inelig eldmal scrn no f/u		M					
G8538	Eld mal scrn no f/u pln		M					
G8539	Cur funct assess & care pln		M					
G8540	Pt inelig funct assess		M					
G8541	No doc cur funct assess		M					
G8542	Pt inelig func asses no pln		M					
G8543	Cur funct asses; no care pln		M					
G8544	CABG measures grp		M					
G8545	HepC measures grp		M					
G8546	CAP measures grp		M					
G8547	IVD measures grp		M					
G8548	HF measures grp		M					
G8549	HepC MG qual act perform		M					
G8550	CAP MG qual act perform		M					
G8551	HF MG qual act perform		M					
G8552	IVD MG qual act perform		M					
G8553	1 Rx via qualified eRx sys		M					
G8556	Ref to doc otolog eval		M					
G8557	Pt inelig ref otolog eval		M					
G8558	No ref to doc otolog eval		M					
G8559	Pt ref doc oto eval		M					
G8560	Pt hx act drain prev 90 days		M					
G8561	Pt inelig for ref oto eval		M					
G8562	Pt no hx act drain 90 d		M					
G8563	Pt no ref oto reas no spec		M					
G8564	Pt ref oto eval		M					
G8565	Ver doc hear loss		M					
G8566	Pt inelig ref oto eval		M					
G8567	Pt no doc hear loss		M					
G8568	Pt no ref otolo no spec		M					
G8569	Prol intubation req		M					
G8570	No prol intub req		M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8571	Ster wd ifx 30 d postop		M					
G8572	No ster wd ifx		M					
G8573	Stk/CVA CABG		M					
G8574	No strk/CVA CABG		M					
G8575	Postop ren insuf		M					
G8576	No postop ren insuf		M					
G8577	Reop req bld grft oth		M					
G8578	No reop req bld grft oth		M					
G8579	Antplt med disch		M					
G8580	Antplt med contraind		M					
G8581	no antplt med disch		M					
G8582	Bblock disch		M					
G8583	Bblock contraind		M					
G8584	No bblock disch		M					
G8585	Antilipid treat disch		M					
G8586	Antlip disch contra		M					
G8587	No antlipid treat disch		M					
G8588	Sys BP <140		M					
G8589	Sys BP >= 140		M					
G8590	Dia BP < 90		M					
G8591	Dia BP >= 90		M					
G8592	No BP measure		M					
G8593	Lipid pn results		M					
G8594	No lipid prof perf		M					
G8595	Ldl < 100		M					
G8596	No LDL perf		M					
G8597	Ldl >= 100		M					
G8598	Asp therp used		M					
G8599	No asp therp used		M					
G8600	tPA initi w/in 3 hrs		M					
G8601	No elig tPA init w/in 3 hrs		M					
G8602	No tPA init w/in 3 hrs		M					
G8603	Spok lang comp score		M					
G8604	No high score spok lang		M					
G8605	No spok lang comp score		M					
G8606	Attention score		M					
G8607	No high score attention		M					
G8608	No attention score		M					
G8609	Memory score		M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8610	No high score memory		M					
G8611	No memory score		M					
G8612	Moto speech score		M					
G8613	No high score moto speech		M					
G8614	No moto speech score		M					
G8615	Reading score		M					
G8616	No high score reading		M					
G8617	No reading score		M					
G8618	Spok lang exp score		M					
G8619	No high score spok lang exp		M					
G8620	No spok lang exp score		M					
G8621	Writing score		M					
G8622	No high score writing		M					
G8623	No writing score		M					
G8624	Swallowing score		M					
G8625	No high score swallowing		M					
G8626	No swallowing score		M					
G8627	Surg proc w/in 30 days		M					
G8628	No surg proc w/in 30 days		M					
G8629	Doc antibio order b/4 surg	NI	M					
G8630	Doc antibio given b/4 surg	NI	M					
G8631	Pt no elg 4 order antbi give	NI	M					
G8632	Doc no antibi order b/4 surg	NI	M					
G8633	Pharm ther osteo rx	NI	M					
G8634	Pt no elg phar ther osteo	NI	M					
G8635	No pharm ther osteo rx	NI	M					
G8636	Flu immun admin/prev rec	NI	M					
G8637	Pt no elg receiv flu immun	NI	M					
G8638	Flu immun no admin/prev rec	NI	M					
G8639	Flu immun admin or prev rec	NI	M					
G8640	Pt no elg rec flu immun	NI	M					
G8641	Flu immun not admin/pre rec	NI	M					
G8642	Hrdshp rural w/o internet	NI	M					
G8643	Hrdshp w/o suff pharm w/eRx	NI	M					
G8644	EP no prescribe priv	NI	M					
G8645	Asthma measures grp	NI	M					
G8646	Asthma MG qual act perform	NI	M					
G8647	Fun stat score knee >= 0	NI	M					
G8648	Fun stat score knee < 0	NI	M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8649	Fun stat score knee pt noelg	NI	M					
G8650	Fun stat score knee not done	NI	M					
G8651	Fun stat score hip >= 0	NI	M					
G8652	Fun stat score hip < 0	NI	M					
G8653	Fun stat score hip pt no elg	NI	M					
G8654	Fun stat score hip not done	NI	M					
G8655	Fun stat score LE >= 0	NI	M					
G8656	Fun stat score LE < 0	NI	M					
G8657	Fun stat score LE pt no elg	NI	M					
G8658	Fun stat score LE not done	NI	M					
G8659	Fun stat score LS >= 0	NI	M					
G8660	Fun stat score LS < 0	NI	M					
G8661	Fun stat score LS pt no elg	NI	M					
G8662	Fun stat score LS not done	NI	M					
G8663	Fun stat score shdl >=0	NI	M					
G8664	Fun stat score shdl < 0	NI	M					
G8665	Fun stat score shdl pt no elg	NI	M					
G8666	Fun stat score shdl not done	NI	M					
G8667	Fun stat score UE >=0	NI	M					
G8668	Fun stat score UE < 0	NI	M					
G8669	Fun stat score UE pt no elg	NI	M					
G8670	Fun stat score UE not done	NI	M					
G8671	Fun stat score neck/TS >=0	NI	M					
G8672	Fun stat score neck/TS < 0	NI	M					
G8673	Fun stat scor nek/TS pt no elg	NI	M					
G8674	Fun stat scor nek/TS not don	NI	M					
G8675	BP Syst >= 140 mmHg	NI	M					
G8676	BP Diast >= 90 mmHg	NI	M					
G8677	BP Syst < 130 mmHg	NI	M					
G8678	BP Syst >=130 - 139 mmHg	NI	M					
G8679	BP Diast < 80 mmHg	NI	M					
G8680	BP Diast 80-89 mmHg	NI	M					
G8681	Pt hosp w/HF	NI	M					
G8682	LVG test perf	NI	M					
G8683	Pt not elig for LVF test	NI	M					
G8684	Pt not hosp w/HF	NI	M					
G8685	LVF test not perf	NI	M					
G8686	Toba smkr curr or 2 hand exp	NI	M					
G8687	No tob smkr cur no 2 hnd exp	NI	M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8688	Smkls tob cur; no 2 hnd exp	NI	M					
G8689	Toba use not assess	NI	M					
G8690	Curr toba smkr or 2 hand exp	NI	M					
G8691	No cur tob smkr no 2 hnd exp	NI	M					
G8692	Curr smkls tob; no 2 hnd exp	NI	M					
G8693	Tobacco no assess	NI	M					
G9001	MCCD, initial rate		B					
G9002	MCCD,maintenance rate		B					
G9003	MCCD, risk adj hi, initial		B					
G9004	MCCD, risk adj lo, initial		B					
G9005	MCCD, risk adj, maintenance		B					
G9006	MCCD, Home monitoring		B					
G9007	MCCD, sch team conf		B					
G9008	Mccd,phys coor-care ovrsght		B					
G9009	MCCD, risk adj, level 3		B					
G9010	MCCD, risk adj, level 4		B					
G9011	MCCD, risk adj, level 5		B					
G9012	Other Specified Case Mgmt		B					
G9013	ESRD demo bundle level I		E					
G9014	ESRD demo bundle-level II		E					
G9016	Demo-smoking cessation coun		E					
G9017	Amantadine HCL 100mg oral		A					
G9018	Zanamivir,inhalation pwd 10m		A					
G9019	Oseltamivir phosphate 75mg		A					
G9020	Rimantadine HCL 100mg oral		A					
G9033	Amantadine HCL oral brand		A					
G9034	Zanamivir, inh pwdr, brand		A					
G9035	Oseltamivir phosp, brand		A					
G9036	Rimantadine HCL, brand		A					
G9041	Low vision rehab occupationa		A					
G9042	Low vision rehab orient/mobi		A					
G9043	Low vision lowvision therapi		A					
G9044	Low vision rehabilate teache		A					
G9050	Oncology work-up evaluation		E					
G9051	Oncology tx decision-mgmt		E					
G9052	Onc surveillance for disease		E					
G9053	Onc expectant management pt		E					
G9054	Onc supervision palliative		E					
G9055	Onc visit unspecified NOS		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9056	Onc prac mgmt adheres guide		E					
G9057	Onc pract mgmt differs trial		E					
G9058	Onc prac mgmt disagree w/gui		E					
G9059	Onc prac mgmt pt opt alterna		E					
G9060	Onc prac mgmt dif pt comorb		E					
G9061	Onc prac cond noadd by guide		E					
G9062	Onc prac guide differs nos		E					
G9063	Onc dx nsclc stgI no progres		M					
G9064	Onc dx nsclc stg2 no progres		M					
G9065	Onc dx nsclc stg3A no progre		M					
G9066	Onc dx nsclc stg3B-4 metasta		M					
G9067	Onc dx nsclc dx unknown nos		M					
G9068	Onc dx sclc/nsclc limited		M					
G9069	Onc dx sclc/nsclc ext at dx		M					
G9070	Onc dx sclc/nsclc ext unknwn		M					
G9071	Onc dx brst stg1-2B HR,nopro		M					
G9072	Onc dx brst stg1-2 noprogres		M					
G9073	Onc dx brst stg3-HR, no pro		M					
G9074	Onc dx brst stg3-noprogress		M					
G9075	Onc dx brst metastic/ recur		M					
G9077	Onc dx prostate T1no progres		M					
G9078	Onc dx prostate T2no progres		M					
G9079	Onc dx prostate T3b-T4noprog		M					
G9080	Onc dx prostate w/rise PSA		M					
G9083	Onc dx prostate unknwn nos		M					
G9084	Onc dx colon t1-3,n1-2,no pr		M					
G9085	Onc dx colon T4, N0 w/o prog		M					
G9086	Onc dx colon T1-4 no dx prog		M					
G9087	Onc dx colon metas evid dx		M					
G9088	Onc dx colon metas noevid dx		M					
G9089	Onc dx colon extent unknown		M					
G9090	Onc dx rectal T1-2 no progr		M					
G9091	Onc dx rectal T3 N0 no prog		M					
G9092	Onc dx rectal T1-3,N1-2noprg		M					
G9093	Onc dx rectal T4,N,M0 no prg		M					
G9094	Onc dx rectal M1 w/mets prog		M					
G9095	Onc dx rectal extent unknwn		M					
G9096	Onc dx esophag T1-T3 noprog		M					
G9097	Onc dx esophageal T4 no prog		M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9098	Onc dx esophageal mets recur		M					
G9099	Onc dx esophageal unknown		M					
G9100	Onc dx gastric no recurrence		M					
G9101	Onc dx gastric p R1-R2noprog		M					
G9102	Onc dx gastric unresectable		M					
G9103	Onc dx gastric recurrent		M					
G9104	Onc dx gastric unknown NOS		M					
G9105	Onc dx pancreatc p R0 res no		M					
G9106	Onc dx pancreatc p R1/R2 no		M					
G9107	Onc dx pancreatic unresectab		M					
G9108	Onc dx pancreatic unknwn NOS		M					
G9109	Onc dx head/neck T1-T2no prg		M					
G9110	Onc dx head/neck T3-4 noprog		M					
G9111	Onc dx head/neck M1 mets rec		M					
G9112	Onc dx head/neck ext unknown		M					
G9113	Onc dx ovarian stg1A-B no pr		M					
G9114	Onc dx ovarian stg1A-B or 2		M					
G9115	Onc dx ovarian stg3/4 noprog		M					
G9116	Onc dx ovarian recurrence		M					
G9117	Onc dx ovarian unknown NOS		M					
G9123	Onc dx CML chronic phase		M					
G9124	Onc dx CML acceler phase		M					
G9125	Onc dx CML blast phase		M					
G9126	Onc dx CML remission		M					
G9128	Onc dx multi myeloma stage I		M					
G9129	Onc dx mult myeloma stg2 hig		M					
G9130	Onc dx multi myeloma unknown		M					
G9131	Onc dx brst unknown NOS		M					
G9132	Onc dx prostate mets no cast		M					
G9133	Onc dx prostate clinical met		M					
G9134	Onc NHLstg 1-2 no relap no		M					
G9135	Onc dx NHL stg 3-4 not relap		M					
G9136	Onc dx NHL trans to lg Bcell		M					
G9137	Onc dx NHL relapse/refractor		M					
G9138	Onc dx NHL stg unknown		M					
G9139	Onc dx CML dx status unknown		M					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9140	Frontier extended stay demo		A					
G9141	Influenza A H1N1,admin w cou		S	0350	0.3826	$26.35	$0.00	$0.00
G9142	Influenza A H1N1, vaccine		E					
G9143	Warfarin respon genetic test		A					
G9147	Outpt IV insulin tx any mea		E					
J0120	Tetracyclin injection		N					
J0128	Abarelix injection	CH	D					
J0129	Abatacept injection		K	9230	.	$19.99	.	$4.00
J0130	Abciximab injection		K	1605	.	$486.03	.	$97.21
J0132	Acetylcysteine injection		K	1272	.	$2.69	.	$0.54
J0133	Acyclovir injection		N					
J0135	Adalimumab injection		K	1083	.	$384.61	.	$76.93
J0150	Injection adenosine 6 MG	CH	N					
J0152	Adenosine injection		K	0917	.	$84.21	.	$16.85
J0170	Adrenalin epinephrin inject	CH	D					
J0171	Adrenalin epinephrine inject	NI	N					
J0180	Agalsidase beta injection		K	9208	.	$134.90	.	$26.98
J0190	Inj biperiden lactate/5 mg	CH	E					
J0200	Alatrofloxacin mesylate		N					
J0205	Alglucerase injection		K	0900	.	$41.58	.	$8.32
J0207	Amifostine		K	7000	.	$315.66	.	$63.14
J0210	Methyldopate hcl injection		K	2210	.	$39.84	.	$7.97
J0215	Alefacept		K	1633	.	$33.05	.	$6.61
J0220	Alglucosidase alfa injection		K	9234	.	$133.92	.	$26.79
J0256	Alpha 1 proteinase inhibitor		K	0901	.	$3.72	.	$0.75
J0270	Alprostadil for injection		B					
J0275	Alprostadil urethral suppos		B					
J0278	Amikacin sulfate injection		N					
J0280	Aminophyllin 250 MG inj		N					
J0282	Amiodarone HCl		N					
J0285	Amphotericin B		N					
J0287	Amphotericin b lipid complex		K	9024	.	$9.73	.	$1.95
J0288	Ampho b cholesteryl sulfate		K	0735	.	$11.89	.	$2.38
J0289	Amphotericin b liposome inj		K	0736	.	$15.53	.	$3.11
J0290	Ampicillin 500 MG inj		N					
J0295	Ampicillin sodium per 1.5 gm		N					
J0300	Amobarbital 125 MG inj		N					
J0330	Succinycholine chloride inj		N					
J0348	Anidulafungin injection	CH	K	1349	.	$1.13	.	$0.23

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0350	Injection anistreplase 30 u		E					
J0360	Hydralazine hcl injection		N					
J0364	Apomorphine hydrochloride		N					
J0365	Aprotonin, 10,000 kiu	CH	N					
J0380	Inj metaraminol bitartrate		N					
J0390	Chloroquine injection		N					
J0395	Arbutamine hcl injection		E					
J0400	Aripiprazole injection		N					
J0456	Azithromycin		N					
J0461	Atropine sulfate injection		N					
J0470	Dimecaprol injection	CH	N					
J0475	Baclofen 10 MG injection		K	9032	.	$202.00	.	$40.40
J0476	Baclofen intrathecal trial		K	1631	.	$72.46	.	$14.50
J0480	Basiliximab		K	1683	.	$2,017.51	.	$403.51
J0500	Dicyclomine injection		N					
J0515	Inj benztropine mesylate	CH	K	1302	.	$58.24	.	$11.65
J0520	Bethanechol chloride inject		N					
J0558	PenG benzathine/procaine inj	NI	N					
J0559	PenG benzathine/procaine inj	CH	D					
J0560	Penicillin g benzathine inj	CH	D					
J0561	Penicillin g benzathine inj	NI	N					
J0570	Penicillin g benzathine inj	CH	D					
J0580	Penicillin g benzathine inj	CH	D					
J0583	Bivalirudin		K	3041	.	$2.52	.	$0.51
J0585	Injection,onabotulinumtoxinA		K	0902	.	$5.44	.	$1.09
J0586	AbobotulinumtoxinA		K	1289	.	$7.62	.	$1.53
J0587	Inj, rimabotulinumtoxinB		K	9018	.	$10.48	.	$2.10
J0592	Buprenorphine hydrochloride		N					
J0594	Busulfan injection		K	1178	.	$16.45	.	$3.29
J0595	Butorphanol tartrate 1 mg		N					
J0597	C-1 esterase, berinert	NI	G	9269	.	$27.53	.	$5.45
J0598	C-1 esterase, cinryze		G	9251	.	$42.75	.	$8.47
J0600	Edetate calcium disodium inj		K	1274	.	$194.86	.	$38.98
J0610	Calcium gluconate injection		N					
J0620	Calcium glycer & lact/10 ML		N					
J0630	Calcitonin salmon injection		K	1220	.	$51.46	.	$10.30
J0636	Inj calcitriol per 0.1 mcg		N					
J0637	Caspofungin acetate		K	9019	.	$11.99	.	$2.40
J0638	Canakinumab injection	NI	K	1311	.	$88.62	.	$17.73

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0640	Leucovorin calcium injection		N					
J0641	Levoleucovorin injection		G	1236	.	$1.14	.	$0.23
J0670	Inj mepivacaine HCL/10 ml		N					
J0690	Cefazolin sodium injection		N					
J0692	Cefepime HCl for injection		N					
J0694	Cefoxitin sodium injection		N					
J0696	Ceftriaxone sodium injection		N					
J0697	Sterile cefuroxime injection		N					
J0698	Cefotaxime sodium injection		N					
J0702	Betamethasone acet&sod phosp		N					
J0704	Betamethasone sod phosp/4 MG	CH	D					
J0706	Caffeine citrate injection		N					
J0710	Cephapirin sodium injection		N					
J0713	Inj ceftazidime per 500 mg		N					
J0715	Ceftizoxime sodium / 500 MG		N					
J0718	Certolizumab pegol inj		G	9249	.	$3.96	.	$0.78
J0720	Chloramphenicol sodium injec		N					
J0725	Chorionic gonadotropin/1000u		N					
J0735	Clonidine hydrochloride		K	0935	.	$24.52	.	$4.91
J0740	Cidofovir injection		K	9033	.	$754.01	.	$150.81
J0743	Cilastatin sodium injection		N					
J0744	Ciprofloxacin iv		N					
J0745	Inj codeine phosphate /30 MG		N					
J0760	Colchicine injection		N					
J0770	Colistimethate sodium inj		N					
J0775	Collagenase, clost hist inj	NI	G	1340	.	$37.51	.	$7.43
J0780	Prochlorperazine injection		N					
J0795	Corticorelin ovine triflutal		K	1684	.	$4.77	.	$0.96
J0800	Corticotropin injection		K	1280	.	$2,418.30	.	$483.66
J0833	Cosyntropin injection NOS		K	0835	.	$69.81	.	$13.97
J0834	Cosyntropin cortrosyn inj		K	1298	.	$82.31	.	$16.47
J0850	Cytomegalovirus imm IV /vial		K	0903	.	$870.53	.	$174.11
J0878	Daptomycin injection		K	9124	.	$0.45	.	$0.09
J0881	Darbepoetin alfa, non-esrd		K	1685	.	$2.87	.	$0.58
J0882	Darbepoetin alfa, esrd use		A					
J0885	Epoetin alfa, non-esrd		K	1686	.	$9.59	.	$1.92
J0886	Epoetin alfa 1000 units ESRD		A					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0894	Decitabine injection		K	9231	.	$30.45	.	$6.09
J0895	Deferoxamine mesylate inj		N					
J0900	Testosterone enanthate inj		N					
J0945	Brompheniramine maleate inj		K	1256	.	$7.50	.	$1.50
J0970	Estradiol valerate injection	CH	D					
J1000	Depo-estradiol cypionate inj		N					
J1020	Methylprednisolone 20 MG inj		N					
J1030	Methylprednisolone 40 MG inj		N					
J1040	Methylprednisolone 80 MG inj		N					
J1051	Medroxyprogesterone inj		N					
J1055	Medrxyprogester acetate inj		E					
J1056	MA/EC contraceptiveinjection		E					
J1060	Testosterone cypionate 1 ML		N					
J1070	Testosterone cypionat 100 MG		N					
J1080	Testosterone cypionat 200 MG		N					
J1094	Inj dexamethasone acetate		N					
J1100	Dexamethasone sodium phos		N					
J1110	Inj dihydroergotamine mesylt		N					
J1120	Acetazolamid sodium injectio		N					
J1160	Digoxin injection		N					
J1162	Digoxin immune fab (ovine)		K	1687	.	$500.91	.	$100.19
J1165	Phenytoin sodium injection		N					
J1170	Hydromorphone injection		N					
J1180	Dyphylline injection		N					
J1190	Dexrazoxane HCl injection		K	0726	.	$207.22	.	$41.45
J1200	Diphenhydramine hcl injectio		N					
J1205	Chlorothiazide sodium inj		K	0747	.	$432.82	.	$86.57
J1212	Dimethyl sulfoxide 50% 50 ML		K	1221	.	$70.46	.	$14.10
J1230	Methadone injection		N					
J1240	Dimenhydrinate injection		N					
J1245	Dipyridamole injection		N					
J1250	Inj dobutamine HCL/250 mg		N					
J1260	Dolasetron mesylate		N					
J1265	Dopamine injection		N					
J1267	Doripenem injection	CH	N					
J1270	Injection, doxercalciferol		N					
J1290	Ecallantide injection	NI	G	9263	.	$275.28	.	$54.54
J1300	Eculizumab injection		K	9236	.	$183.75	.	$36.75
J1320	Amitriptyline injection		N					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1324	Enfuvirtide injection	CH	N					
J1325	Epoprostenol injection		N					
J1327	Eptifibatide injection		K	1607	.	$19.91	.	$3.99
J1330	Ergonovine maleate injection		N					
J1335	Ertapenem injection		N					
J1364	Erythro lactobionate /500 MG		N					
J1380	Estradiol valerate 10 MG inj		N					
J1390	Estradiol valerate 20 MG inj	CH	D					
J1410	Inj estrogen conjugate 25 MG		K	9038	.	$92.21	.	$18.45
J1430	Ethanolamine oleate 100 mg		K	1688	.	$148.55	.	$29.71
J1435	Injection estrone per 1 MG	CH	E					
J1436	Etidronate disodium inj	CH	N					
J1438	Etanercept injection		K	1608	.	$198.44	.	$39.69
J1440	Filgrastim 300 mcg injection		K	0728	.	$231.22	.	$46.25
J1441	Filgrastim 480 mcg injection		K	7049	.	$363.35	.	$72.67
J1450	Fluconazole		N					
J1451	Fomepizole, 15 mg		K	1689	.	$7.49	.	$1.50
J1452	Intraocular Fomivirsen na		E					
J1453	Fosaprepitant injection	CH	K	9242	.	$1.67	.	$0.34
J1455	Foscarnet sodium injection		N					
J1457	Gallium nitrate injection		K	0878	.	$2.01	.	$0.41
J1458	Galsulfase injection		K	9224	.	$333.68	.	$66.74
J1459	Inj IVIG privigen 500 mg	CH	K	1214	.	$34.76	.	$6.96
J1460	Gamma globulin 1 CC inj		K	3043	.	$18.71	.	$3.75
J1470	Gamma globulin 2 CC inj	CH	D					
J1480	Gamma globulin 3 CC inj	CH	D					
J1490	Gamma globulin 4 CC inj	CH	D					
J1500	Gamma globulin 5 CC inj	CH	D					
J1510	Gamma globulin 6 CC inj	CH	D					
J1520	Gamma globulin 7 CC inj	CH	D					
J1530	Gamma globulin 8 CC inj	CH	D					
J1540	Gamma globulin 9 CC inj	CH	D					
J1550	Gamma globulin 10 CC inj	CH	D					
J1559	Hizentra injection	NI	K	1312	.	$13.23	.	$2.65
J1560	Gamma globulin > 10 CC inj		K	0933	.	$187.06	.	$37.42
J1561	Gamunex injection		K	0948	.	$37.29	.	$7.46
J1562	Vivaglobin, inj		K	1275	.	$7.10	.	$1.42
J1566	Immune globulin, powder		K	2731	.	$29.12	.	$5.83
J1568	Octagam injection		K	0943	.	$36.42	.	$7.29

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1569	Gammagard liquid injection		K	0944	.	$38.13	.	$7.63
J1570	Ganciclovir sodium injection		N					
J1571	Hepagam b im injection	CH	K	0946	.	$50.43	.	$10.09
J1572	Flebogamma injection		K	0947	.	$35.79	.	$7.16
J1573	Hepagam b intravenous, inj	CH	K	1138	.	$50.43	.	$10.09
J1580	Garamycin gentamicin inj		N					
J1590	Gatifloxacin injection		N					
J1595	Injection glatiramer acetate		K	1015	.	$93.19	.	$18.64
J1599	Ivig non-lyophilized, NOS	NI	N					
J1600	Gold sodium thiomaleate inj		N					
J1610	Glucagon hydrochloride/1 MG		K	9042	.	$85.12	.	$17.03
J1620	Gonadorelin hydroch/ 100 mcg	CH	N					
J1626	Granisetron hcl injection		N					
J1630	Haloperidol injection		N					
J1631	Haloperidol decanoate inj		N					
J1640	Hemin, 1 mg		K	1690	.	$8.41	.	$1.69
J1642	Inj heparin sodium per 10 u		N					
J1644	Inj heparin sodium per 1000u		N					
J1645	Dalteparin sodium		N					
J1650	Inj enoxaparin sodium		N					
J1652	Fondaparinux sodium	CH	N					
J1655	Tinzaparin sodium injection		N					
J1670	Tetanus immune globulin inj		K	1670	.	$230.10	.	$46.02
J1675	Histrelin acetate		B					
J1680	Human fibrinogen conc inj		G	1290	.	$72.89	.	$14.44
J1700	Hydrocortisone acetate inj		N					
J1710	Hydrocortisone sodium ph inj		N					
J1720	Hydrocortisone sodium succ i		N					
J1730	Diazoxide injection		K	1740	.	$1.04	.	$0.21
J1740	Ibandronate sodium injection		K	9229	.	$142.82	.	$28.57
J1742	Ibutilide fumarate injection		K	9044	.	$188.42	.	$37.69
J1743	Idursulfase injection		K	9232	.	$450.74	.	$90.15
J1745	Infliximab injection		K	7043	.	$59.96	.	$12.00
J1750	Inj iron dextran		K	1237	.	$11.88	.	$2.38
J1756	Iron sucrose injection		K	9046	.	$0.36	.	$0.08
J1785	Injection imiglucerase /unit	CH	D					
J1786	Imuglucerase injection	NI	K	1327	.	$41.58	.	$8.32
J1790	Droperidol injection		N					
J1800	Propranolol injection		N					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1810	Droperidol/fentanyl inj		E					
J1815	Insulin injection		N					
J1817	Insulin for insulin pump use	CH	N					
J1825	Interferon beta-1a	CH	D					
J1826	Interferon Beta-1A inj	NI	E					
J1830	Interferon beta-1b / .25 MG		K	0910	.	$182.83	.	$36.57
J1835	Itraconazole injection		N					
J1840	Kanamycin sulfate 500 MG inj		N					
J1850	Kanamycin sulfate 75 MG inj		N					
J1885	Ketorolac tromethamine inj		N					
J1890	Cephalothin sodium injection		N					
J1930	Lanreotide injection		K	9237	.	$29.75	.	$5.95
J1931	Laronidase injection		K	9209	.	$25.31	.	$5.07
J1940	Furosemide injection		N					
J1945	Lepirudin		K	1693	.	$277.67	.	$55.54
J1950	Leuprolide acetate /3.75 MG		K	0800	.	$520.49	.	$104.10
J1953	Levetiracetam injection	CH	N					
J1955	Inj levocarnitine per 1 gm		B					
J1956	Levofloxacin injection		N					
J1960	Levorphanol tartrate inj		N					
J1980	Hyoscyamine sulfate inj		N					
J1990	Chlordiazepoxide injection		N					
J2001	Lidocaine injection		N					
J2010	Lincomycin injection		N					
J2020	Linezolid injection		K	9001	.	$33.05	.	$6.61
J2060	Lorazepam injection		N					
J2150	Mannitol injection		N					
J2170	Mecasermin injection	CH	K	1308	.	$20.37	.	$4.08
J2175	Meperidine hydrochl /100 MG		N					
J2180	Meperidine/promethazine inj		N					
J2185	Meropenem		N					
J2210	Methylergonovin maleate inj		N					
J2248	Micafungin sodium injection		K	9227	.	$1.06	.	$0.22
J2250	Inj midazolam hydrochloride		N					
J2260	Inj milrinone lactate / 5 MG		N					
J2270	Morphine sulfate injection		N					
J2271	Morphine so4 injection 100mg		N					
J2275	Morphine sulfate injection		N					
J2278	Ziconotide injection		K	1694	.	$6.54	.	$1.31

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2280	Inj, moxifloxacin 100 mg		N					
J2300	Inj nalbuphine hydrochloride		N					
J2310	Inj naloxone hydrochloride		N					
J2315	Naltrexone, depot form		K	0759	.	$2.36	.	$0.48
J2320	Nandrolone decanoate 50 MG		K	1285	.	$9.27	.	$1.86
J2321	Nandrolone decanoate 100 MG	CH	D					
J2322	Nandrolone decanoate 200 MG	CH	D					
J2323	Natalizumab injection		K	9126	.	$8.68	.	$1.74
J2325	Nesiritide injection		K	1695	.	$39.90	.	$7.98
J2353	Octreotide injection, depot		K	1207	.	$110.99	.	$22.20
J2354	Octreotide inj, non-depot		N					
J2355	Oprelvekin injection		K	7011	.	$242.29	.	$48.46
J2357	Omalizumab injection		K	9300	.	$20.19	.	$4.04
J2358	Olanzapine long-acting inj	NI	K	1331	.	$2.73	.	$0.55
J2360	Orphenadrine injection		N					
J2370	Phenylephrine hcl injection		N					
J2400	Chloroprocaine hcl injection		N					
J2405	Ondansetron hcl injection		N					
J2410	Oxymorphone hcl injection		N					
J2425	Palifermin injection		K	1696	.	$11.25	.	$2.25
J2426	Paliperidone palmitate inj	NI	G	9255	.	$6.52	.	$1.29
J2430	Pamidronate disodium /30 MG	CH	N					
J2440	Papaverin hcl injection		N					
J2460	Oxytetracycline injection		E					
J2469	Palonosetron hcl		K	9210	.	$18.23	.	$3.65
J2501	Paricalcitol		N					
J2503	Pegaptenib sodium injection		K	1697	.	$1,011.14	.	$202.23
J2504	Pegademase bovine, 25 iu		K	1739	.	$245.00	.	$49.00
J2505	Injection, pegfilgrastim 6mg		K	9119	.	$2,441.95	.	$488.39
J2510	Penicillin g procaine inj	CH	K	1346	.	$11.59	.	$2.32
J2513	Pentastarch 10% solution		K	1222	.	$160.29	.	$32.06
J2515	Pentobarbital sodium inj		N					
J2540	Penicillin g potassium inj		N					
J2543	Piperacillin/tazobactam		N					
J2545	Pentamidine non-comp unit		B					
J2550	Promethazine hcl injection		N					
J2560	Phenobarbital sodium inj		N					
J2562	Plerixafor injection		G	9252	.	$281.67	.	$55.80
J2590	Oxytocin injection		N					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2597	Inj desmopressin acetate		N					
J2650	Prednisolone acetate inj		N					
J2670	Totazoline hcl injection		N					
J2675	Inj progesterone per 50 MG		N					
J2680	Fluphenazine decanoate 25 MG		N					
J2690	Procainamide hcl injection		N					
J2700	Oxacillin sodium injeciton	CH	K	1347	.	$2.18	.	$0.44
J2710	Neostigmine methylslfte inj		N					
J2720	Inj protamine sulfate/10 MG		N					
J2724	Protein c concentrate		K	1139	.	$12.43	.	$2.49
J2725	Inj protirelin per 250 mcg		N					
J2730	Pralidoxime chloride inj		K	1023	.	$89.82	.	$17.97
J2760	Phentolaine mesylate inj		N					
J2765	Metoclopramide hcl injection		N					
J2770	Quinupristin/dalfopristin		K	2770	.	$158.36	.	$31.68
J2778	Ranibizumab injection		K	9233	.	$401.39	.	$80.28
J2780	Ranitidine hydrochloride inj		N					
J2783	Rasburicase		K	0738	.	$177.57	.	$35.52
J2785	Regadenoson injection	CH	K	9244	.	$50.80	.	$10.16
J2788	Rho d immune globulin 50 mcg		K	9023	.	$22.45	.	$4.49
J2790	Rho d immune globulin inj		K	0884	.	$83.54	.	$16.71
J2791	Rhophylac injection		K	0945	.	$5.13	.	$1.03
J2792	Rho(D) immune globulin h, sd		K	1609	.	$17.25	.	$3.45
J2793	Rilonacept injection		K	1291	.	$23.86	.	$4.78
J2794	Risperidone, long acting		K	9125	.	$5.00	.	$1.00
J2795	Ropivacaine HCl injection		N					
J2796	Romiplostim injection	CH	K	9245	.	$44.71	.	$8.95
J2800	Methocarbamol injection		N					
J2805	Sincalide injection	CH	K	1348	.	$71.95	.	$14.39
J2810	Inj theophylline per 40 MG		N					
J2820	Sargramostim injection		K	0731	.	$23.65	.	$4.73
J2850	Inj secretin synthetic human		K	1700	.	$27.23	.	$5.45
J2910	Aurothioglucose injeciton		N					
J2916	Na ferric gluconate complex		N					
J2920	Methylprednisolone injection		N					
J2930	Methylprednisolone injection		N					
J2940	Somatrem injection	CH	N					
J2941	Somatropin injection		K	7034	.	$57.51	.	$11.51

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2950	Promazine hcl injection		N					
J2993	Reteplase injection		K	9005	.	$1,300.11	.	$260.03
J2995	Inj streptokinase /250000 IU		K	1226	.	$47.57	.	$9.52
J2997	Alteplase recombinant		K	7048	.	$38.34	.	$7.67
J3000	Streptomycin injection		N					
J3010	Fentanyl citrate injeciton		N					
J3030	Sumatriptan succinate / 6 MG	CH	N					
J3070	Pentazocine injection		N					
J3095	Televancin injection	NI	G	9258	.	$1.87	.	$0.37
J3101	Tenecteplase injection		K	9002	.	$47.18	.	$9.44
J3105	Terbutaline sulfate inj		N					
J3110	Teriparatide injection		B					
J3120	Testosterone enanthate inj		N					
J3130	Testosterone enanthate inj		N					
J3140	Testosterone suspension inj		N					
J3150	Testosteron propionate inj		N					
J3230	Chlorpromazine hcl injection		N					
J3240	Thyrotropin injection		K	9108	.	$1,043.12	.	$208.63
J3243	Tigecycline injection		K	9228	.	$1.23	.	$0.25
J3246	Tirofiban HCl		K	7041	.	$7.96	.	$1.60
J3250	Trimethobenzamide hcl inj		N					
J3260	Tobramycin sulfate injection		N					
J3262	Tocilizumab injection	NI	G	9264	.	$3.48	.	$0.69
J3265	Injection torsemide 10 mg/ml		N					
J3280	Thiethylperazine maleate inj		N					
J3285	Treprostinil injection		K	1701	.	$59.92	.	$11.99
J3300	Triamcinolone A inj PRS-free		K	1253	.	$3.19	.	$0.64
J3301	Triamcinolone acet inj NOS		N					
J3302	Triamcinolone diacetate inj		N					
J3303	Triamcinolone hexacetonl inj		N					
J3305	Inj trimetrexate glucoronate	CH	N					
J3310	Perphenazine injeciton	CH	K	1304	.	$30.91	.	$6.19
J3315	Triptorelin pamoate		K	9122	.	$180.22	.	$36.05
J3320	Spectinomycn di-hcl inj	CH	E					
J3350	Urea injection	CH	K	1306	.	$82.18	.	$16.44
J3355	Urofollitropin, 75 iu		K	1741	.	$59.28	.	$11.86
J3357	Ustekinumab injection	NI	G	9261	.	$107.11	.	$21.22
J3360	Diazepam injection		N					
J3364	Urokinase 5000 IU injection		N					

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J3365	Urokinase 250,000 IU inj		K	7036	.	$453.41	.	$90.69
J3370	Vancomycin hcl injection		N					
J3385	Velaglucerase alfa	NI	G	9271	.	$350.60	.	$69.46
J3396	Verteporfin injection		K	1203	.	$9.49	.	$1.90
J3400	Triflupromazine hcl inj	CH	E					
J3410	Hydroxyzine hcl injection		N					
J3411	Thiamine hcl 100 mg		N					
J3415	Pyridoxine hcl 100 mg		N					
J3420	Vitamin b12 injection		N					
J3430	Vitamin k phytonadione inj		N					
J3465	Injection, voriconazole		K	1052	.	$5.88	.	$1.18
J3470	Hyaluronidase injection		N					
J3471	Ovine, up to 999 USP units		N					
J3472	Ovine, 1000 USP units		N					
J3473	Hyaluronidase recombinant		N					
J3475	Inj magnesium sulfate		N					
J3480	Inj potassium chloride		N					
J3485	Zidovudine		N					
J3486	Ziprasidone mesylate		N					
J3487	Zoledronic acid		K	9115	.	$220.99	.	$44.20
J3488	Reclast injection		K	0951	.	$220.55	.	$44.11
J3490	Drugs unclassified injection		N					
J3520	Edetate disodium per 150 mg		E					
J3530	Nasal vaccine inhalation		N					
J3535	Metered dose inhaler drug		E					
J3570	Laetrile amygdalin vit B17		E					
J3590	Unclassified biologics		N					
J7030	Normal saline solution infus		N					
J7040	Normal saline solution infus		N					
J7042	5% dextrose/normal saline		N					
J7050	Normal saline solution infus		N					
J7060	5% dextrose/water		N					
J7070	D5w infusion		N					
J7100	Dextran 40 infusion		N					
J7110	Dextran 75 infusion		N					
J7120	Ringers lactate infusion		N					
J7130	Hypertonic saline solution		N					
J7184	Wilate injection	NI	G	9267	.	$71.19	.	$14.10
J7185	Xyntha inj		K	1268	.	$1.05	.	$0.21

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7186	Antihemophilic viii/vwf comp		K	1213	.	$0.91	.	$0.19
J7187	Humate-P, inj		K	1704	.	$0.87	.	$0.18
J7189	Factor viia		K	1705	.	$1.36	.	$0.28
J7190	Factor viii		K	0925	.	$0.88	.	$0.18
J7191	Factor VIII (porcine)		K	1279	.	$1.17	.	$0.24
J7192	Factor viii recombinant NOS		K	0927	.	$1.09	.	$0.22
J7193	Factor IX non-recombinant		K	0931	.	$0.89	.	$0.18
J7194	Factor ix complex		K	0928	.	$0.88	.	$0.18
J7195	Factor IX recombinant		K	0932	.	$1.11	.	$0.23
J7196	Antithrombin recombinant	NI	K	1332	.	$2.93	.	$0.59
J7197	Antithrombin iii injection		K	1263	.	$2.51	.	$0.51
J7198	Anti-inhibitor		K	0929	.	$1.58	.	$0.32
J7199	Hemophilia clot factor noc		B					
J7300	Intraut copper contraceptive		E					
J7302	Levonorgestrel iu contracept		E					
J7303	Contraceptive vaginal ring		E					
J7304	Contraceptive hormone patch		E					
J7306	Levonorgestrel implant sys		E					
J7307	Etonogestrel implant system		E					
J7308	Aminolevulinic acid hcl top		K	7308	.	$137.64	.	$27.53
J7309	Methyl aminolevulinate, top	NI	K	1338	.	$0.72	.	$0.15
J7310	Ganciclovir long act implant		K	0913	.	$16,800.00	.	$3,360.00
J7311	Fluocinolone acetonide implt		K	9225	.	$19,162.50	.	$3,832.50
J7312	Dexamethasone intra implant	NI	G	9256	.	$196.10	.	$38.85
J7321	Hyalgan/supartz inj per dose		K	0873	.	$89.67	.	$17.94
J7323	Euflexxa inj per dose		K	0875	.	$125.97	.	$25.20
J7324	Orthovisc inj per dose		K	0877	.	$173.45	.	$34.69
J7325	Synvisc or Synvisc-One		K	0874	.	$11.83	.	$2.37
J7330	Cultured chondrocytes implnt		B					
J7335	Capsaicin 8% patch	NI	G	9268	.	$25.55	.	$5.06
J7500	Azathioprine oral 50mg		N					
J7501	Azathioprine parenteral		K	0887	.	$102.84	.	$20.57
J7502	Cyclosporine oral 100 mg	CH	N					
J7504	Lymphocyte immune globulin		K	0890	.	$492.26	.	$98.46
J7505	Monoclonal antibodies		K	7038	.	$1,122.83	.	$224.57
J7506	Prednisone oral		N					
J7507	Tacrolimus oral per 1 MG	CH	N					
J7509	Methylprednisolone oral		N					
J7510	Prednisolone oral per 5 mg		N					

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J7511	Antithymocyte globuln rabbit		K	9104	.	$413.57	.	$82.72
J7513	Daclizumab, parenteral		K	1612	.	$521.38	.	$104.28
J7515	Cyclosporine oral 25 mg	CH	N					
J7516	Cyclosporin parenteral 250mg	CH	N					
J7517	Mycophenolate mofetil oral	CH	N					
J7518	Mycophenolic acid		N					
J7520	Sirolimus, oral	CH	N					
J7525	Tacrolimus injection		K	9006	.	$138.17	.	$27.64
J7599	Immunosuppressive drug noc		N					
J7604	Acetylcysteine comp unit		M					
J7605	Arformoterol non-comp unit		M					
J7606	Formoterol fumarate, inh		M					
J7607	Levalbuterol comp con		M					
J7608	Acetylcysteine non-comp unit		M					
J7609	Albuterol comp unit		M					
J7610	Albuterol comp con		M					
J7611	Albuterol non-comp con		M					
J7612	Levalbuterol non-comp con		M					
J7613	Albuterol non-comp unit		M					
J7614	Levalbuterol non-comp unit		M					
J7615	Levalbuterol comp unit		M					
J7620	Albuterol ipratrop non-comp		M					
J7622	Beclomethasone comp unit		M					
J7624	Betamethasone comp unit		M					
J7626	Budesonide non-comp unit		M					
J7627	Budesonide comp unit		M					
J7628	Bitolterol mesylate comp con		M					
J7629	Bitolterol mesylate comp unt		M					
J7631	Cromolyn sodium noncomp unit		M					
J7632	Cromolyn sodium comp unit		M					
J7633	Budesonide non-comp con		M					
J7634	Budesonide comp con		M					
J7635	Atropine comp con		M					
J7636	Atropine comp unit		M					
J7637	Dexamethasone comp con		M					
J7638	Dexamethasone comp unit		M					
J7639	Dornase alfa non-comp unit		M					
J7640	Formoterol comp unit		E					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7641	Flunisolide comp unit		M					
J7642	Glycopyrrolate comp con		M					
J7643	Glycopyrrolate comp unit		M					
J7644	Ipratropium bromide non-comp		M					
J7645	Ipratropium bromide comp		M					
J7647	Isoetharine comp con		M					
J7648	Isoetharine non-comp con		M					
J7649	Isoetharine non-comp unit		M					
J7650	Isoetharine comp unit		M					
J7657	Isoproterenol comp con		M					
J7658	Isoproterenol non-comp con		M					
J7659	Isoproterenol non-comp unit		M					
J7660	Isoproterenol comp unit		M					
J7667	Metaproterenol comp con		M					
J7668	Metaproterenol non-comp con		M					
J7669	Metaproterenol non-comp unit		M					
J7670	Metaproterenol comp unit		M					
J7674	Methacholine chloride, neb		N					
J7676	Pentamidine comp unit dose		M					
J7680	Terbutaline sulf comp con		M					
J7681	Terbutaline sulf comp unit		M					
J7682	Tobramycin non-comp unit		M					
J7683	Triamcinolone comp con		M					
J7684	Triamcinolone comp unit		M					
J7685	Tobramycin comp unit		M					
J7686	Treprostinil, non-comp unit	NI	M					
J7699	Inhalation solution for DME		M					
J7799	Non-inhalation drug for DME		N					
J8498	Antiemetic rectal/supp NOS		B					
J8499	Oral prescrip drug non chemo		E					
J8501	Oral aprepitant		K	0868	.	$5.79	.	$1.16
J8510	Oral busulfan	CH	K	1307	.	$3.66	.	$0.74
J8515	Cabergoline, oral 0.25mg		E					
J8520	Capecitabine, oral, 150 mg		K	7042	.	$6.78	.	$1.36
J8521	Capecitabine, oral, 500 mg		K	0934	.	$22.37	.	$4.48
J8530	Cyclophosphamide oral 25 MG		N					
J8540	Oral dexamethasone		N					
J8560	Etoposide oral 50 MG		K	0802	.	$25.21	.	$5.65
J8562	Oral fludarabine phosphate	NI	G	1339	.	$80.14	.	$15.88

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J8565	Gefitinib oral		E					
J8597	Antiemetic drug oral NOS		N					
J8600	Melphalan oral 2 MG		N					
J8610	Methotrexate oral 2.5 MG		N					
J8650	Nabilone oral		N					
J8700	Temozolomide		K	1086	.	$9.07	.	$1.82
J8705	Topotecan oral		G	1238	.	$77.10	.	$15.27
J8999	Oral prescription drug chemo		B					
J9000	Doxorubicin hcl injection		N					
J9001	Doxorubicin hcl liposome inj		K	7046	.	$482.21	.	$96.45
J9010	Alemtuzumab injection		K	9110	.	$567.94	.	$113.59
J9015	Aldesleukin injection		K	0807	.	$913.37	.	$182.68
J9017	Arsenic trioxide injection		K	9012	.	$36.90	.	$7.38
J9020	Asparaginase injection		K	0814	.	$62.87	.	$12.58
J9025	Azacitidine injection		K	1709	.	$5.08	.	$1.02
J9027	Clofarabine injection		K	1710	.	$114.32	.	$22.87
J9031	Bcg live intravesical vac		K	0809	.	$113.85	.	$22.77
J9033	Bendamustine injection	CH	K	9243	.	$18.33	.	$3.67
J9035	Bevacizumab injection		K	9214	.	$57.89	.	$11.58
J9040	Bleomycin sulfate injection		N					
J9041	Bortezomib injection		K	9207	.	$38.92	.	$7.79
J9045	Carboplatin injection		N					
J9050	Carmustine injection		K	0812	.	$174.22	.	$34.85
J9055	Cetuximab injection		K	9215	.	$49.27	.	$9.86
J9060	Cisplatin 10 MG injection		N					
J9062	Cisplatin 50 MG injection	CH	D					
J9065	Inj cladribine per 1 MG		K	0858	.	$24.10	.	$4.82
J9070	Cyclophosphamide 100 MG inj		N					
J9080	Cyclophosphamide 200 MG inj	CH	D					
J9090	Cyclophosphamide 500 MG inj	CH	D					
J9091	Cyclophosphamide 1.0 grm inj	CH	D					
J9092	Cyclophosphamide 2.0 grm inj	CH	D					
J9093	Cyclophosphamide lyophilized	CH	D					
J9094	Cyclophosphamide lyophilized	CH	D					
J9095	Cyclophosphamide lyophilized	CH	D					
J9096	Cyclophosphamide lyophilized	CH	D					
J9097	Cyclophosphamide lyophilized	CH	D					
J9098	Cytarabine liposome inj		K	1166	.	$466.07	.	$93.22
J9100	Cytarabine hcl 100 MG inj		N					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9110	Cytarabine hcl 500 MG inj	CH	D					
J9120	Dactinomycin injection		K	0752	.	$586.62	.	$117.37
J9130	Dacarbazine 100 mg inj		N					
J9140	Dacarbazine 200 MG inj	CH	D					
J9150	Daunorubicin injection		K	0820	.	$15.35	.	$3.07
J9151	Daunorubicin citrate inj		K	0821	.	$57.12	.	$11.43
J9155	Degarelix injection		G	1296	.	$2.52	.	$0.50
J9160	Denileukin diftitox inj		K	1084	.	$1,526.44	.	$305.29
J9165	Diethylstilbestrol injection	CH	N					
J9171	Docetaxel injection		K	0823	.	$17.84	.	$3.57
J9175	Elliotts b solution per ml		N					
J9178	Inj, epirubicin hcl, 2 mg		K	1167	.	$1.78	.	$0.36
J9181	Etoposide injection		N					
J9185	Fludarabine phosphate inj		K	0842	.	$138.26	.	$27.66
J9190	Fluorouracil injection		N					
J9200	Floxuridine injection		K	0827	.	$41.33	.	$8.27
J9201	Gemcitabine hcl injection		K	0828	.	$146.95	.	$29.39
J9202	Goserelin acetate implant		K	0810	.	$192.46	.	$38.50
J9206	Irinotecan injection		K	0830	.	$6.07	.	$1.22
J9207	Ixabepilone injection	CH	K	9240	.	$63.14	.	$12.63
J9208	Ifosfomide injection		K	0831	.	$33.82	.	$6.77
J9209	Mesna injection	CH	N					
J9211	Idarubicin hcl injection		K	0832	.	$102.98	.	$20.60
J9212	Interferon alfacon-1 inj		K	1266	.	$6.49	.	$1.30
J9213	Interferon alfa-2a inj	CH	N					
J9214	Interferon alfa-2b inj		K	0836	.	$15.91	.	$3.19
J9215	Interferon alfa-n3 inj		K	0865	.	$18.06	.	$3.62
J9216	Interferon gamma 1-b inj		K	0838	.	$426.87	.	$85.38
J9217	Leuprolide acetate suspnsion		K	9217	.	$206.25	.	$41.25
J9218	Leuprolide acetate injeciton		K	0861	.	$4.74	.	$0.95
J9219	Leuprolide acetate implant		K	7051	.	$4,774.35	.	$954.87
J9225	Vantas implant	CH	K	1711	.	$1,470.47	.	$294.10
J9226	Supprelin LA implant	CH	K	1142	.	$15,141.06	.	$3,028.22
J9230	Mechlorethamine hcl inj		K	0751	.	$153.01	.	$30.61
J9245	Inj melphalan hydrochl 50 MG		K	0840	.	$1,388.61	.	$277.73
J9250	Methotrexate sodium inj		N					
J9260	Methotrexate sodium inj		N					
J9261	Nelarabine injection		K	0825	.	$108.42	.	$21.69
J9263	Oxaliplatin		K	1738	.	$4.67	.	$0.94

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9264	Paclitaxel protein bound		K	1712	.	$9.30	.	$1.86
J9265	Paclitaxel injection	CH	K	1309	.	$7.38	.	$1.48
J9266	Pegaspargase injection		K	0843	.	$2,460.13	.	$492.03
J9268	Pentostatin injection		K	0844	.	$1,217.22	.	$243.45
J9270	Plicamycin (mithramycin) inj		N					
J9280	Mitomycin 5 MG inj		K	1232	.	$20.57	.	$4.12
J9290	Mitomycin 20 MG inj	CH	D					
J9291	Mitomycin 40 MG inj	CH	D					
J9293	Mitoxantrone hydrochl / 5 MG		K	0864	.	$40.45	.	$8.09
J9300	Gemtuzumab ozogamicin inj		K	9004	.	$2,660.02	.	$532.01
J9302	Ofatumumab injection	NI	G	9260	.	$45.47	.	$9.01
J9303	Panitumumab injection		K	9235	.	$86.56	.	$17.32
J9305	Pemetrexed injection		K	9213	.	$50.96	.	$10.20
J9307	Pralatrexate injection	NI	G	9259	.	$165.63	.	$32.81
J9310	Rituximab injection		K	0849	.	$588.27	.	$117.66
J9315	Romidepsin injection	NI	G	9265	.	$219.30	.	$43.45
J9320	Streptozocin injection		K	0850	.	$275.09	.	$55.02
J9328	Temozolomide injection		G	9253	.	$4.90	.	$0.97
J9330	Temsirolimus injection		K	1168	.	$50.35	.	$10.07
J9340	Thiotepa injection		K	0851	.	$113.01	.	$22.61
J9350	Topotecan injection	CH	D					
J9351	Topotecan injection	NI	K	1350	.	$27.01	.	$5.41
J9355	Trastuzumab injection		K	1613	.	$67.64	.	$13.53
J9357	Valrubicin injection		K	1235	.	$954.10	.	$190.82
J9360	Vinblastine sulfate inj		N					
J9370	Vincristine sulfate 1 MG inj		N					
J9375	Vincristine sulfate 2 MG inj	CH	D					
J9380	Vincristine sulfate 5 MG inj	CH	D					
J9390	Vinorelbine tartrate inj		N					
J9395	Injection, Fulvestrant		K	9120	.	$82.23	.	$16.45
J9600	Porfimer sodium injection		K	0856	.	$2,907.23	.	$581.45
J9999	Chemotherapy drug		N					
K0001	Standard wheelchair		Y					
K0002	Stnd hemi (low seat) whlchr		Y					
K0003	Lightweight wheelchair		Y					
K0004	High strength ltwt whlchr		Y					
K0005	Ultralightweight wheelchair		Y					
K0006	Heavy duty wheelchair		Y					
K0007	Extra heavy duty wheelchair		Y					

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0009	Other manual wheelchair/base		Y					
K0010	Stnd wt frame power whlchr		Y					
K0011	Stnd wt pwr whlchr w control		Y					
K0012	Ltwt portbl power whlchr		Y					
K0014	Other power whlchr base		Y					
K0015	Detach non-adjus hght armrst		Y					
K0017	Detach adjust armrest base		Y					
K0018	Detach adjust armrst upper		Y					
K0019	Arm pad each		Y					
K0020	Fixed adjust armrest pair		Y					
K0037	High mount flip-up footrest		Y					
K0038	Leg strap each		Y					
K0039	Leg strap h style each		Y					
K0040	Adjustable angle footplate		Y					
K0041	Large size footplate each		Y					
K0042	Standard size footplate each		Y					
K0043	Ftrst lower extension tube		Y					
K0044	Ftrst upper hanger bracket		Y					
K0045	Footrest complete assembly		Y					
K0046	Elevat legrst low extension		Y					
K0047	Elevat legrst up hangr brack		Y					
K0050	Ratchet assembly		Y					
K0051	Cam relese assem first/lgrst		Y					
K0052	Swingaway detach footrest		Y					
K0053	Elevate footrest articulate		Y					
K0056	Seat ht <17 or >=21 ltwt wc		Y					
K0065	Spoke protectors		Y					
K0069	Rear whl complete solid tire		Y					
K0070	Rear whl compl pneum tire		Y					
K0071	Front castr compl pneum tire		Y					
K0072	Frnt cstr cmpl sem-pneum tir		Y					
K0073	Caster pin lock each		Y					
K0077	Front caster assem complete		Y					
K0098	Drive belt power wheelchair		Y					
K0105	Iv hanger		Y					
K0108	W/c component-accessory NOS		Y					
K0195	Elevating whlchair leg rests		Y					
K0455	Pump uninterrupted infusion		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0462	Temporary replacement eqpmnt		Y					
K0552	Supply/ext inf pump syr type		Y					
K0601	Repl batt silver oxide 1.5 v		Y					
K0602	Repl batt silver oxide 3 v		Y					
K0603	Repl batt alkaline 1.5 v		Y					
K0604	Repl batt lithium 3.6 v		Y					
K0605	Repl batt lithium 4.5 v		Y					
K0606	AED garment w elec analysis		Y					
K0607	Repl batt for AED		Y					
K0608	Repl garment for AED		Y					
K0609	Repl electrode for AED		Y					
K0669	Seat/back cus no dmepdac ver		Y					
K0672	Removable soft interface LE		A					
K0730	Ctrl dose inh drug deliv sys		Y					
K0733	12-24hr sealed lead acid		Y					
K0734	Adj skin pro w/c cus wd<22in	CH	D					
K0735	Adj skin pro wc cus wd>=22in	CH	D					
K0736	Adj skin pro/pos wc cus<22in	CH	D					
K0737	Adj skin pro/pos wc cus>=22"	CH	D					
K0738	Portable gas oxygen system		Y					
K0739	Repair/svc DME non-oxygen eq		Y					
K0740	Repair/svc oxygen equipment		E					
K0800	POV group 1 std up to 300lbs		Y					
K0801	POV group 1 hd 301-450 lbs		Y					
K0802	POV group 1 vhd 451-600 lbs		Y					
K0806	POV group 2 std up to 300lbs		Y					
K0807	POV group 2 hd 301-450 lbs		Y					
K0808	POV group 2 vhd 451-600 lbs		Y					
K0812	Power operated vehicle NOC		Y					
K0813	PWC gp 1 std port seat/back		Y					
K0814	PWC gp 1 std port cap chair		Y					
K0815	PWC gp 1 std seat/back		Y					
K0816	PWC gp 1 std cap chair		Y					
K0820	PWC gp 2 std port seat/back		Y					
K0821	PWC gp 2 std port cap chair		Y					
K0822	PWC gp 2 std seat/back		Y					
K0823	PWC gp 2 std cap chair		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0824	PWC gp 2 hd seat/back		Y					
K0825	PWC gp 2 hd cap chair		Y					
K0826	PWC gp 2 vhd seat/back		Y					
K0827	PWC gp vhd cap chair		Y					
K0828	PWC gp 2 xtra hd seat/back		Y					
K0829	PWC gp 2 xtra hd cap chair		Y					
K0830	PWC gp2 std seat elevate s/b		Y					
K0831	PWC gp2 std seat elevate cap		Y					
K0835	PWC gp2 std sing pow opt s/b		Y					
K0836	PWC gp2 std sing pow opt cap		Y					
K0837	PWC gp 2 hd sing pow opt s/b		Y					
K0838	PWC gp 2 hd sing pow opt cap		Y					
K0839	PWC gp2 vhd sing pow opt s/b		Y					
K0840	PWC gp2 xhd sing pow opt s/b		Y					
K0841	PWC gp2 std mult pow opt s/b		Y					
K0842	PWC gp2 std mult pow opt cap		Y					
K0843	PWC gp2 hd mult pow opt s/b		Y					
K0848	PWC gp 3 std seat/back		Y					
K0849	PWC gp 3 std cap chair		Y					
K0850	PWC gp 3 hd seat/back		Y					
K0851	PWC gp 3 hd cap chair		Y					
K0852	PWC gp 3 vhd seat/back		Y					
K0853	PWC gp 3 vhd cap chair		Y					
K0854	PWC gp 3 xhd seat/back		Y					
K0855	PWC gp 3 xhd cap chair		Y					
K0856	PWC gp3 std sing pow opt s/b		Y					
K0857	PWC gp3 std sing pow opt cap		Y					
K0858	PWC gp3 hd sing pow opt s/b		Y					
K0859	PWC gp3 hd sing pow opt cap		Y					
K0860	PWC gp3 vhd sing pow opt s/b		Y					
K0861	PWC gp3 std mult pow opt s/b		Y					
K0862	PWC gp3 hd mult pow opt s/b		Y					
K0863	PWC gp3 vhd mult pow opt s/b		Y					
K0864	PWC gp3 xhd mult pow opt s/b		Y					
K0868	PWC gp 4 std seat/back		Y					
K0869	PWC gp 4 std cap chair		Y					
K0870	PWC gp 4 hd seat/back		Y					
K0871	PWC gp 4 vhd seat/back		Y					
K0877	PWC gp4 std sing pow opt s/b		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0878	PWC gp4 std sing pow opt cap		Y					
K0879	PWC gp4 hd sing pow opt s/b		Y					
K0880	PWC gp4 vhd sing pow opt s/b		Y					
K0884	PWC gp4 std mult pow opt s/b		Y					
K0885	PWC gp4 std mult pow opt cap		Y					
K0886	PWC gp4 hd mult pow s/b		Y					
K0890	PWC gp5 ped sing pow opt s/b		Y					
K0891	PWC gp5 ped mult pow opt s/b		Y					
K0898	Power wheelchair NOC		Y					
K0899	Pow mobil dev no dmepdac		Y					
L0112	Cranial cervical orthosis		A					
L0113	Cranial cervical torticollis		A					
L0120	Cerv flexible non-adjustable		A					
L0130	Flex thermoplastic collar mo		A					
L0140	Cervical semi-rigid adjustab		A					
L0150	Cerv semi-rig adj molded chn		A					
L0160	Cerv semi-rig wire occ/mand		A					
L0170	Cervical collar molded to pt		A					
L0172	Cerv col thermplas foam 2 pi		A					
L0174	Cerv col foam 2 piece w thor		A					
L0180	Cer post col occ/man sup adj		A					
L0190	Cerv collar supp adj cerv ba		A					
L0200	Cerv col supp adj bar & thor		A					
L0220	Thor rib belt custom fabrica		A					
L0430	Dewall posture protector		A					
L0450	TLSO flex prefab thoracic		A					
L0452	tlso flex custom fab thoraci		A					
L0454	TLSO flex prefab sacrococ-T9		A					
L0456	TLSO flex prefab		A					
L0458	TLSO 2Mod symphis-xipho pre		A					
L0460	TLSO2Mod symphysis-stern pre		A					
L0462	TLSO 3Mod sacro-scap pre		A					
L0464	TLSO 4Mod sacro-scap pre		A					
L0466	TLSO rigid frame pre soft ap		A					
L0468	TLSO rigid frame prefab pelv		A					
L0470	TLSO rigid frame pre subclav		A					
L0472	TLSO rigid frame hyperex pre		A					
L0480	TLSO rigid plastic custom fa		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L0482	TLSO rigid lined custom fab		A					
L0484	TLSO rigid plastic cust fab		A					
L0486	TLSO rigidlined cust fab two		A					
L0488	TLSO rigid lined pre one pie		A					
L0490	TLSO rigid plastic pre one		A					
L0491	TLSO 2 piece rigid shell		A					
L0492	TLSO 3 piece rigid shell		A					
L0621	SIO flex pelvisacral prefab		A					
L0622	SIO flex pelvisacral custom		A					
L0623	SIO panel prefab		A					
L0624	SIO panel custom		A					
L0625	LO flexibl L1-below L5 pre		A					
L0626	LO sag stays/panels pre-fab		A					
L0627	LO sagitt rigid panel prefab		A					
L0628	LO flex w/o rigid stays pre		A					
L0629	LSO flex w/rigid stays cust		A					
L0630	LSO post rigid panel pre		A					
L0631	LSO sag-coro rigid frame pre		A					
L0632	LSO sag rigid frame cust		A					
L0633	LSO flexion control prefab		A					
L0634	LSO flexion control custom		A					
L0635	LSO sagit rigid panel prefab		A					
L0636	LSO sagittal rigid panel cus		A					
L0637	LSO sag-coronal panel prefab		A					
L0638	LSO sag-coronal panel custom		A					
L0639	LSO s/c shell/panel prefab		A					
L0640	LSO s/c shell/panel custom		A					
L0700	Ctlso a-p-l control molded		A					
L0710	Ctlso a-p-l control w/ inter		A					
L0810	Halo cervical into jckt vest		A					
L0820	Halo cervical into body jack		A					
L0830	Halo cerv into milwaukee typ		A					
L0859	MRI compatible system		A					
L0861	Halo repl liner/interface		A					
L0970	Tlso corset front		A					
L0972	Lso corset front		A					
L0974	Tlso full corset		A					
L0976	Lso full corset		A					
L0978	Axillary crutch extension		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L0980	Peroneal straps pair		A					
L0982	Stocking supp grips set of f		A					
L0984	Protective body sock each		A					
L0999	Add to spinal orthosis NOS		A					
L1000	Ctlso milwauke initial model		A					
L1001	CTLSO infant immobilizer		A					
L1005	Tension based scoliosis orth		A					
L1010	Ctlso axilla sling		A					
L1020	Kyphosis pad		A					
L1025	Kyphosis pad floating		A					
L1030	Lumbar bolster pad		A					
L1040	Lumbar or lumbar rib pad		A					
L1050	Sternal pad		A					
L1060	Thoracic pad		A					
L1070	Trapezius sling		A					
L1080	Outrigger		A					
L1085	Outrigger bil w/ vert extens		A					
L1090	Lumbar sling		A					
L1100	Ring flange plastic/leather		A					
L1110	Ring flange plas/leather mol		A					
L1120	Covers for upright each		A					
L1200	Furnsh initial orthosis only		A					
L1210	Lateral thoracic extension		A					
L1220	Anterior thoracic extension		A					
L1230	Milwaukee type superstructur		A					
L1240	Lumbar derotation pad		A					
L1250	Anterior asis pad		A					
L1260	Anterior thoracic derotation		A					
L1270	Abdominal pad		A					
L1280	Rib gusset (elastic) each		A					
L1290	Lateral trochanteric pad		A					
L1300	Body jacket mold to patient		A					
L1310	Post-operative body jacket		A					
L1499	Spinal orthosis NOS		A					
L1500	Thkao mobility frame		A					
L1510	Thkao standing frame		A					
L1520	Thkao swivel walker		A					
L1600	Abduct hip flex frejka w cvr		A					
L1610	Abduct hip flex frejka covr		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L1620	Abduct hip flex pavlik harne		A					
L1630	Abduct control hip semi-flex		A					
L1640	Pelv band/spread bar thigh c		A					
L1650	HO abduction hip adjustable		A					
L1652	HO bi thighcuffs w sprdr bar		A					
L1660	HO abduction static plastic		A					
L1680	Pelvic & hip control thigh c		A					
L1685	Post-op hip abduct custom fa		A					
L1686	HO post-op hip abduction		A					
L1690	Combination bilateral HO		A					
L1700	Leg perthes orth toronto typ		A					
L1710	Legg perthes orth newington		A					
L1720	Legg perthes orthosis trilat		A					
L1730	Legg perthes orth scottish r		A					
L1755	Legg perthes patten bottom t		A					
L1810	Ko elastic with joints		A					
L1820	Ko elas w/ condyle pads & jo		A					
L1830	Ko immobilizer canvas longit		A					
L1831	Knee orth pos locking joint		A					
L1832	KO adj jnt pos rigid support		A					
L1834	Ko w/0 joint rigid molded to		A					
L1836	Rigid KO wo joints		A					
L1840	Ko derot ant cruciate custom		A					
L1843	KO single upright custom fit		A					
L1844	Ko w/adj jt rot cntrl molded		A					
L1845	Ko w/ adj flex/ext rotat cus		A					
L1846	Ko w adj flex/ext rotat mold		A					
L1847	KO adjustable w air chambers		A					
L1850	Ko swedish type		A					
L1860	Ko supracondylar socket mold		A					
L1900	Afo sprng wir drsflx calf bd		A					
L1902	Afo ankle gauntlet		A					
L1904	Afo molded ankle gauntlet		A					
L1906	Afo multiligamentus ankle su		A					
L1907	AFO supramalleolar custom		A					
L1910	Afo sing bar clasp attach sh		A					
L1920	Afo sing upright w/ adjust s		A					
L1930	Afo plastic		A					
L1932	Afo rig ant tib prefab TCF/=		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L1940	Afo molded to patient plasti		A					
L1945	Afo molded plas rig ant tib		A					
L1950	Afo spiral molded to pt plas		A					
L1951	AFO spiral prefabricated		A					
L1960	Afo pos solid ank plastic mo		A					
L1970	Afo plastic molded w/ankle j		A					
L1971	AFO w/ankle joint, prefab		A					
L1980	Afo sing solid stirrup calf		A					
L1990	Afo doub solid stirrup calf		A					
L2000	Kafo sing fre stirr thi/calf		A					
L2005	KAFO sng/dbl mechanical act		A					
L2010	Kafo sng solid stirrup w/o j		A					
L2020	Kafo dbl solid stirrup band/		A					
L2030	Kafo dbl solid stirrup w/o j		A					
L2034	KAFO pla sin up w/wo k/a cus		A					
L2035	KAFO plastic pediatric size		A					
L2036	Kafo plas doub free knee mol		A					
L2037	Kafo plas sing free knee mol		A					
L2038	Kafo w/o joint mulfi-axis an		A					
L2040	Hkafo torsion bil rot straps		A					
L2050	Hkafo torsion cable hip pelv		A					
L2060	Hkafo torsion ball bearing j		A					
L2070	Hkafo torsion unilat rot str		A					
L2080	Hkafo unilat torsion cable		A					
L2090	Hkafo unilat torsion ball br		A					
L2106	Afo tib fx cast plaster mold		A					
L2108	Afo tib fx cast molded to pt		A					
L2112	Afo tibial fracture soft		A					
L2114	Afo tib fx semi-rigid		A					
L2116	Afo tibial fracture rigid		A					
L2126	Kafo fem fx cast thermoplas		A					
L2128	Kafo fem fx cast molded to p		A					
L2132	Kafo femoral fx cast soft		A					
L2134	Kafo fem fx cast semi-rigid		A					
L2136	Kafo femoral fx cast rigid		A					
L2180	Plas shoe insert w ank joint		A					
L2182	Drop lock knee		A					
L2184	Limited motion knee joint		A					
L2186	Adj motion knee jnt lerman t		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2188	Quadrilateral brim		A					
L2190	Waist belt		A					
L2192	Pelvic band & belt thigh fla		A					
L2200	Limited ankle motion ea jnt		A					
L2210	Dorsiflexion assist each joi		A					
L2220	Dorsi & plantar flex ass/res		A					
L2230	Split flat caliper stirr & p		A					
L2232	Rocker bottom, contact AFO		A					
L2240	Round caliper and plate atta		A					
L2250	Foot plate molded stirrup at		A					
L2260	Reinforced solid stirrup		A					
L2265	Long tongue stirrup		A					
L2270	Varus/valgus strap padded/li		A					
L2275	Plastic mod low ext pad/line		A					
L2280	Molded inner boot		A					
L2300	Abduction bar jointed adjust		A					
L2310	Abduction bar-straight		A					
L2320	Non-molded lacer		A					
L2330	Lacer molded to patient mode		A					
L2335	Anterior swing band		A					
L2340	Pre-tibial shell molded to p		A					
L2350	Prosthetic type socket molde		A					
L2360	Extended steel shank		A					
L2370	Patten bottom		A					
L2375	Torsion ank & half solid sti		A					
L2380	Torsion straight knee joint		A					
L2385	Straight knee joint heavy du		A					
L2387	Add LE poly knee custom KAFO		A					
L2390	Offset knee joint each		A					
L2395	Offset knee joint heavy duty		A					
L2397	Suspension sleeve lower ext		A					
L2405	Knee joint drop lock ea jnt		A					
L2415	Knee joint cam lock each joi		A					
L2425	Knee disc/dial lock/adj flex		A					
L2430	Knee jnt ratchet lock ea jnt		A					
L2492	Knee lift loop drop lock rin		A					
L2500	Thi/glut/ischia wgt bearing		A					
L2510	Th/wght bear quad-lat brim m		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2520	Th/wght bear quad-lat brim c		A					
L2525	Th/wght bear nar m-l brim mo		A					
L2526	Th/wght bear nar m-l brim cu		A					
L2530	Thigh/wght bear lacer non-mo		A					
L2540	Thigh/wght bear lacer molded		A					
L2550	Thigh/wght bear high roll cu		A					
L2570	Hip clevis type 2 posit jnt		A					
L2580	Pelvic control pelvic sling		A					
L2600	Hip clevis/thrust bearing fr		A					
L2610	Hip clevis/thrust bearing lo		A					
L2620	Pelvic control hip heavy dut		A					
L2622	Hip joint adjustable flexion		A					
L2624	Hip adj flex ext abduct cont		A					
L2627	Plastic mold recipro hip & c		A					
L2628	Metal frame recipro hip & ca		A					
L2630	Pelvic control band & belt u		A					
L2640	Pelvic control band & belt b		A					
L2650	Pelv & thor control gluteal		A					
L2660	Thoracic control thoracic ba		A					
L2670	Thorac cont paraspinal uprig		A					
L2680	Thorac cont lat support upri		A					
L2750	Plating chrome/nickel pr bar		A					
L2755	Carbon graphite lamination		A					
L2760	Extension per extension per		A					
L2768	Ortho sidebar disconnect		A					
L2780	Non-corrosive finish		A					
L2785	Drop lock retainer each		A					
L2795	Knee control full kneecap		A					
L2800	Knee cap medial or lateral p		A					
L2810	Knee control condylar pad		A					
L2820	Soft interface below knee se		A					
L2830	Soft interface above knee se		A					
L2840	Tibial length sock fx or equ		A					
L2850	Femoral lgth sock fx or equa		A					
L2861	Torsion mechanism knee/ankle		E					
L2999	Lower extremity orthosis NOS		A					
L3000	Ft insert ucb berkeley shell		A					
L3001	Foot insert remov molded spe		A					
L3002	Foot insert plastazote or eq		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3003	Foot insert silicone gel eac		A					
L3010	Foot longitudinal arch suppo		A					
L3020	Foot longitud/metatarsal sup		A					
L3030	Foot arch support remov prem		A					
L3031	Foot lamin/prepreg composite		A					
L3040	Ft arch suprt premold longit		A					
L3050	Foot arch supp premold metat		A					
L3060	Foot arch supp longitud/meta		A					
L3070	Arch suprt att to sho longit		A					
L3080	Arch supp att to shoe metata		A					
L3090	Arch supp att to shoe long/m		A					
L3100	Hallus-valgus nght dynamic s		A					
L3140	Abduction rotation bar shoe		A					
L3150	Abduct rotation bar w/o shoe		A					
L3160	Shoe styled positioning dev		A					
L3170	Foot plastic heel stabilizer		A					
L3201	Oxford w supinat/pronat inf		A					
L3202	Oxford w/ supinat/pronator c		A					
L3203	Oxford w/ supinator/pronator		A					
L3204	Hightop w/ supp/pronator inf		A					
L3206	Hightop w/ supp/pronator chi		A					
L3207	Hightop w/ supp/pronator jun		A					
L3208	Surgical boot each infant		A					
L3209	Surgical boot each child		A					
L3211	Surgical boot each junior		A					
L3212	Benesch boot pair infant		A					
L3213	Benesch boot pair child		A					
L3214	Benesch boot pair junior		A					
L3215	Orthopedic ftwear ladies oxf		E					
L3216	Orthoped ladies shoes dpth i		E					
L3217	Ladies shoes hightop depth i		E					
L3219	Orthopedic mens shoes oxford		E					
L3221	Orthopedic mens shoes dpth i		E					
L3222	Mens shoes hightop depth inl		E					
L3224	Woman's shoe oxford brace		A					
L3225	Man's shoe oxford brace		A					
L3230	Custom shoes depth inlay		A					
L3250	Custom mold shoe remov prost		A					
L3251	Shoe molded to pt silicone s		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3252	Shoe molded plastazote cust		A					
L3253	Shoe molded plastazote cust		A					
L3254	Orth foot non-stndard size/w		A					
L3255	Orth foot non-standard size/		A					
L3257	Orth foot add charge split s		A					
L3260	Ambulatory surgical boot eac		E					
L3265	Plastazote sandal each		A					
L3300	Sho lift taper to metatarsal		A					
L3310	Shoe lift elev heel/sole neo		A					
L3320	Shoe lift elev heel/sole cor		A					
L3330	Lifts elevation metal extens		A					
L3332	Shoe lifts tapered to one-ha		A					
L3334	Shoe lifts elevation heel /i		A					
L3340	Shoe wedge sach		A					
L3350	Shoe heel wedge		A					
L3360	Shoe sole wedge outside sole		A					
L3370	Shoe sole wedge between sole		A					
L3380	Shoe clubfoot wedge		A					
L3390	Shoe outflare wedge		A					
L3400	Shoe metatarsal bar wedge ro		A					
L3410	Shoe metatarsal bar between		A					
L3420	Full sole/heel wedge btween		A					
L3430	Sho heel count plast reinfor		A					
L3440	Heel leather reinforced		A					
L3450	Shoe heel sach cushion type		A					
L3455	Shoe heel new leather standa		A					
L3460	Shoe heel new rubber standar		A					
L3465	Shoe heel thomas with wedge		A					
L3470	Shoe heel thomas extend to b		A					
L3480	Shoe heel pad & depress for		A					
L3485	Shoe heel pad removable for		A					
L3500	Ortho shoe add leather insol		A					
L3510	Orthopedic shoe add rub insl		A					
L3520	O shoe add felt w leath insl		A					
L3530	Ortho shoe add half sole		A					
L3540	Ortho shoe add full sole		A					
L3550	O shoe add standard toe tap		A					
L3560	O shoe add horseshoe toe tap		A					
L3570	O shoe add instep extension		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3580	O shoe add instep velcro clo		A					
L3590	O shoe convert to sof counte		A					
L3595	Ortho shoe add march bar		A					
L3600	Trans shoe calip plate exist		A					
L3610	Trans shoe caliper plate new		A					
L3620	Trans shoe solid stirrup exi		A					
L3630	Trans shoe solid stirrup new		A					
L3640	Shoe dennis browne splint bo		A					
L3649	Orthopedic shoe modifica NOS		A					
L3650	Shlder fig 8 abduct restrain		A					
L3660	Abduct restrainer canvas&web	CH	D					
L3670	Acromio/clavicular canvas&we	CH	D					
L3671	SO cap design w/o jnts CF		A					
L3672	SO airplane w/o jnts CF	CH	D					
L3673	SO airplane w/joint CF	CH	D					
L3674	SO airplane w/wo joint CF	NI	A					
L3675	Canvas vest SO	CH	D					
L3677	SO hard plastic stabilizer	CH	A					
L3702	EO w/o joints CF		A					
L3710	Elbow elastic with metal joi		A					
L3720	Forearm/arm cuffs free motio		A					
L3730	Forearm/arm cuffs ext/flex a		A					
L3740	Cuffs adj lock w/ active con		A					
L3760	EO withjoint, Prefabricated		A					
L3762	Rigid EO wo joints		A					
L3763	EWHO rigid w/o jnts CF		A					
L3764	EWHO w/joint(s) CF		A					
L3765	EWHFO rigid w/o jnts CF		A					
L3766	EWHFO w/joint(s) CF		A					
L3806	WHFO w/joint(s) custom fab		A					
L3807	WHFO,no joint, prefabricated		A					
L3808	WHFO, rigid w/o joints		A					
L3891	Torsion mechanism wrist/elbo		E					
L3900	Hinge extension/flex wrist/f		A					
L3901	Hinge ext/flex wrist finger		A					
L3904	Whfo electric custom fitted		A					
L3905	WHO w/nontorsion jnt(s) CF		A					
L3906	WHO w/o joints CF		A					
L3908	Wrist cock-up non-molded		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3912	Flex glove w/elastic finger		A					
L3913	HFO w/o joints CF		A					
L3915	WHO w nontor jnt(s) prefab		A					
L3917	Prefab metacarpl fx orthosis		A					
L3919	HO w/o joints CF		A					
L3921	HFO w/joint(s) CF		A					
L3923	HFO w/o joints PF		A					
L3925	FO pip/dip with joint/spring		A					
L3927	FO pip/dip w/o joint/spring		A					
L3929	HFO nontorsion joint, prefab		A					
L3931	WHFO nontorsion joint prefab		A					
L3933	FO w/o joints CF		A					
L3935	FO nontorsion joint CF		A					
L3956	Add joint upper ext orthosis		A					
L3960	Sewho airplan desig abdu pos		A					
L3961	SEWHO cap design w/o jnts CF		A					
L3962	Sewho erbs palsey design abd		A					
L3964	Seo mobile arm sup att to wc		Y					
L3965	Arm supp att to wc rancho ty		Y					
L3966	Mobile arm supports reclinin		Y					
L3967	SEWHO airplane w/o jnts CF		A					
L3968	Friction dampening arm supp		Y					
L3969	Monosuspension arm/hand supp		Y					
L3970	Elevat proximal arm support		Y					
L3971	SEWHO cap design w/jnt(s) CF		A					
L3972	Offset/lat rocker arm w/ ela		Y					
L3973	SEWHO airplane w/jnt(s) CF		A					
L3974	Mobile arm support supinator		Y					
L3975	SEWHFO cap design w/o jnt CF		A					
L3976	SEWHFO airplane w/o jnts CF		A					
L3977	SEWHFO cap desgn w/jnt(s) CF		A					
L3978	SEWHFO airplane w/jnt(s) CF		A					
L3980	Upp ext fx orthosis humeral		A					
L3982	Upper ext fx orthosis rad/ul		A					
L3984	Upper ext fx orthosis wrist		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3995	Sock fracture or equal each		A					
L3999	Upper limb orthosis NOS		A					
L4000	Repl girdle milwaukee orth		A					
L4002	Replace strap, any orthosis		A					
L4010	Replace trilateral socket br		A					
L4020	Replace quadlat socket brim		A					
L4030	Replace socket brim cust fit		A					
L4040	Replace molded thigh lacer		A					
L4045	Replace non-molded thigh lac		A					
L4050	Replace molded calf lacer		A					
L4055	Replace non-molded calf lace		A					
L4060	Replace high roll cuff		A					
L4070	Replace prox & dist upright		A					
L4080	Repl met band kafo-afo prox		A					
L4090	Repl met band kafo-afo calf/		A					
L4100	Repl leath cuff kafo prox th		A					
L4110	Repl leath cuff kafo-afo cal		A					
L4130	Replace pretibial shell		A					
L4205	Ortho dvc repair per 15 min		A					
L4210	Orth dev repair/repl minor p		A					
L4350	Ankle control orthosi prefab		A					
L4360	Pneumati walking boot prefab		A					
L4370	Pneumatic full leg splint		A					
L4380	Pneumatic knee splint		A					
L4386	Non-pneum walk boot prefab		A					
L4392	Replace AFO soft interface		A					
L4394	Replace foot drop spint		A					
L4396	Static AFO		A					
L4398	Foot drop splint recumbent		A					
L4631	Afo, walk boot type, cus fab	NI	A					
L5000	Sho insert w arch toe filler		A					
L5010	Mold socket ank hgt w/ toe f		A					
L5020	Tibial tubercle hgt w/ toe f		A					
L5050	Ank symes mold sckt sach ft		A					
L5060	Symes met fr leath socket ar		A					
L5100	Molded socket shin sach foot		A					
L5105	Plast socket jts/thgh lacer		A					
L5150	Mold sckt ext knee shin sach		A					
L5160	Mold socket bent knee shin s		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5200	Kne sing axis fric shin sach		A					
L5210	No knee/ankle joints w/ ft b		A					
L5220	No knee joint with artic ali		A					
L5230	Fem focal defic constant fri		A					
L5250	Hip canad sing axi cons fric		A					
L5270	Tilt table locking hip sing		A					
L5280	Hemipelvect canad sing axis		A					
L5301	BK mold socket SACH ft endo		A					
L5311	Knee disart, SACH ft, endo		A					
L5321	AK open end SACH		A					
L5331	Hip disart canadian SACH ft		A					
L5341	Hemipelvectomy canadian SACH		A					
L5400	Postop dress & 1 cast chg bk		A					
L5410	Postop dsg bk ea add cast ch		A					
L5420	Postop dsg & 1 cast chg ak/d		A					
L5430	Postop dsg ak ea add cast ch		A					
L5450	Postop app non-wgt bear dsg		A					
L5460	Postop app non-wgt bear dsg		A					
L5500	Init bk ptb plaster direct		A					
L5505	Init ak ischal plstr direct		A					
L5510	Prep BK ptb plaster molded		A					
L5520	Perp BK ptb thermopls direct		A					
L5530	Prep BK ptb thermopls molded		A					
L5535	Prep BK ptb open end socket		A					
L5540	Prep BK ptb laminated socket		A					
L5560	Prep AK ischial plast molded		A					
L5570	Prep AK ischial direct form		A					
L5580	Prep AK ischial thermo mold		A					
L5585	Prep AK ischial open end		A					
L5590	Prep AK ischial laminated		A					
L5595	Hip disartic sach thermopls		A					
L5600	Hip disart sach laminat mold		A					
L5610	Above knee hydracadence		A					
L5611	Ak 4 bar link w/fric swing		A					
L5613	Ak 4 bar ling w/hydraul swig		A					
L5614	4-bar link above knee w/swng		A					
L5616	Ak univ multiplex sys frict		A					
L5617	AK/BK self-aligning unit ea		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5618	Test socket symes		A					
L5620	Test socket below knee		A					
L5622	Test socket knee disarticula		A					
L5624	Test socket above knee		A					
L5626	Test socket hip disarticulat		A					
L5628	Test socket hemipelvectomy		A					
L5629	Below knee acrylic socket		A					
L5630	Syme typ expandabl wall sckt		A					
L5631	Ak/knee disartic acrylic soc		A					
L5632	Symes type ptb brim design s		A					
L5634	Symes type poster opening so		A					
L5636	Symes type medial opening so		A					
L5637	Below knee total contact		A					
L5638	Below knee leather socket		A					
L5639	Below knee wood socket		A					
L5640	Knee disarticulat leather so		A					
L5642	Above knee leather socket		A					
L5643	Hip flex inner socket ext fr		A					
L5644	Above knee wood socket		A					
L5645	Bk flex inner socket ext fra		A					
L5646	Below knee cushion socket		A					
L5647	Below knee suction socket		A					
L5648	Above knee cushion socket		A					
L5649	Isch containmt/narrow m-l so		A					
L5650	Tot contact ak/knee disart s		A					
L5651	Ak flex inner socket ext fra		A					
L5652	Suction susp ak/knee disart		A					
L5653	Knee disart expand wall sock		A					
L5654	Socket insert symes		A					
L5655	Socket insert below knee		A					
L5656	Socket insert knee articulat		A					
L5658	Socket insert above knee		A					
L5661	Multi-durometer symes		A					
L5665	Multi-durometer below knee		A					
L5666	Below knee cuff suspension		A					
L5668	Socket insert w/o lock lower		A					
L5670	Bk molded supracondylar susp		A					
L5671	BK/AK locking mechanism		A					
L5672	Bk removable medial brim sus		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5673	Socket insert w lock mech		A					
L5676	Bk knee joints single axis p		A					
L5677	Bk knee joints polycentric p		A					
L5678	Bk joint covers pair		A					
L5679	Socket insert w/o lock mech		A					
L5680	Bk thigh lacer non-molded		A					
L5681	Intl custm cong/latyp insert		A					
L5682	Bk thigh lacer glut/ischia m		A					
L5683	Initial custom socket insert		A					
L5684	Bk fork strap		A					
L5685	Below knee sus/seal sleeve		A					
L5686	Bk back check		A					
L5688	Bk waist belt webbing		A					
L5690	Bk waist belt padded and lin		A					
L5692	Ak pelvic control belt light		A					
L5694	Ak pelvic control belt pad/l		A					
L5695	Ak sleeve susp neoprene/equa		A					
L5696	Ak/knee disartic pelvic join		A					
L5697	Ak/knee disartic pelvic band		A					
L5698	Ak/knee disartic silesian ba		A					
L5699	Shoulder harness		A					
L5700	Replace socket below knee		A					
L5701	Replace socket above knee		A					
L5702	Replace socket hip		A					
L5703	Symes ankle w/o (SACH) foot		A					
L5704	Custom shape cover BK		A					
L5705	Custom shape cover AK		A					
L5706	Custom shape cvr knee disart		A					
L5707	Custom shape cvr hip disart		A					
L5710	Kne-shin exo sng axi mnl loc		A					
L5711	Knee-shin exo mnl lock ultra		A					
L5712	Knee-shin exo frict swg & st		A					
L5714	Knee-shin exo variable frict		A					
L5716	Knee-shin exo mech stance ph		A					
L5718	Knee-shin exo frct swg & sta		A					
L5722	Knee-shin pneum swg frct exo		A					
L5724	Knee-shin exo fluid swing ph		A					
L5726	Knee-shin ext jnts fld swg e		A					
L5728	Knee-shin fluid swg & stance		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5780	Knee-shin pneum/hydra pneum		A					
L5781	Lower limb pros vacuum pump		A					
L5782	HD low limb pros vacuum pump		A					
L5785	Exoskeletal bk ultralt mater		A					
L5790	Exoskeletal ak ultra-light m		A					
L5795	Exoskel hip ultra-light mate		A					
L5810	Endoskel knee-shin mnl lock		A					
L5811	Endo knee-shin mnl lck ultra		A					
L5812	Endo knee-shin frct swg & st		A					
L5814	Endo knee-shin hydral swg ph		A					
L5816	Endo knee-shin polyc mch sta		A					
L5818	Endo knee-shin frct swg & st		A					
L5822	Endo knee-shin pneum swg frc		A					
L5824	Endo knee-shin fluid swing p		A					
L5826	Miniature knee joint		A					
L5828	Endo knee-shin fluid swg/sta		A					
L5830	Endo knee-shin pneum/swg pha		A					
L5840	Multi-axial knee/shin system		A					
L5845	Knee-shin sys stance flexion		A					
L5848	Knee-shin sys hydraul stance		A					
L5850	Endo ak/hip knee extens assi		A					
L5855	Mech hip extension assist		A					
L5856	Elec knee-shin swing/stance		A					
L5857	Elec knee-shin swing only		A					
L5858	Stance phase only		A					
L5910	Endo below knee alignable sy		A					
L5920	Endo ak/hip alignable system		A					
L5925	Above knee manual lock		A					
L5930	High activity knee frame		A					
L5940	Endo bk ultra-light material		A					
L5950	Endo ak ultra-light material		A					
L5960	Endo hip ultra-light materia		A					
L5961	Endo poly hip, pneu/hyd/rot	NI	A					
L5962	Below knee flex cover system		A					
L5964	Above knee flex cover system		A					
L5966	Hip flexible cover system		A					
L5968	Multiaxial ankle w dorsiflex		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5970	Foot external keel sach foot		A					
L5971	SACH foot, replacement		A					
L5972	Flexible keel foot		A					
L5973	Ank-foot sys dors-plant flex		A					
L5974	Foot single axis ankle/foot		A					
L5975	Combo ankle/foot prosthesis		A					
L5976	Energy storing foot		A					
L5978	Ft prosth multiaxial ankl/ft		A					
L5979	Multi-axial ankle/ft prosth		A					
L5980	Flex foot system		A					
L5981	Flex-walk sys low ext prosth		A					
L5982	Exoskeletal axial rotation u		A					
L5984	Endoskeletal axial rotation		A					
L5985	Lwr ext dynamic prosth pylon		A					
L5986	Multi-axial rotation unit		A					
L5987	Shank ft w vert load pylon		A					
L5988	Vertical shock reducing pylo		A					
L5990	User adjustable heel height		A					
L5999	Lowr extremity prosthes NOS		A					
L6000	Par hand robin-aids thum rem		A					
L6010	Hand robin-aids little/ring		A					
L6020	Part hand robin-aids no fing		A					
L6025	Part hand disart myoelectric		A					
L6050	Wrst MLd sck flx hng tri pad		A					
L6055	Wrst mold sock w/exp interfa		A					
L6100	Elb mold sock flex hinge pad		A					
L6110	Elbow mold sock suspension t		A					
L6120	Elbow mold doub split soc ste		A					
L6130	Elbow stump activated lock h		A					
L6200	Elbow mold outsid lock hinge		A					
L6205	Elbow molded w/ expand inter		A					
L6250	Elbow inter loc elbow forarm		A					
L6300	Shlder disart int lock elbow		A					
L6310	Shoulder passive restor comp		A					
L6320	Shoulder passive restor cap		A					
L6350	Thoracic intern lock elbow		A					
L6360	Thoracic passive restor comp		A					
L6370	Thoracic passive restor cap		A					
L6380	Postop dsg cast chg wrst/elb		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6382	Postop dsg cast chg elb dis/		A					
L6384	Postop dsg cast chg shlder/t		A					
L6386	Postop ea cast chg & realign		A					
L6388	Postop applicat rigid dsg on		A					
L6400	Below elbow prosth tiss shap		A					
L6450	Elb disart prosth tiss shap		A					
L6500	Above elbow prosth tiss shap		A					
L6550	Shldr disar prosth tiss shap		A					
L6570	Scap thorac prosth tiss shap		A					
L6580	Wrist/elbow bowden cable mol		A					
L6582	Wrist/elbow bowden cbl dir f		A					
L6584	Elbow fair lead cable molded		A					
L6586	Elbow fair lead cable dir fo		A					
L6588	Shdr fair lead cable molded		A					
L6590	Shdr fair lead cable direct		A					
L6600	Polycentric hinge pair		A					
L6605	Single pivot hinge pair		A					
L6610	Flexible metal hinge pair		A					
L6611	Additional switch, ext power		A					
L6615	Disconnect locking wrist uni		A					
L6616	Disconnect insert locking wr		A					
L6620	Flexion/extension wrist unit		A					
L6621	Flex/ext wrist w/wo friction		A					
L6623	Spring-ass rot wrst w/ latch		A					
L6624	Flex/ext/rotation wrist unit		A					
L6625	Rotation wrst w/ cable lock		A					
L6628	Quick disconn hook adapter o		A					
L6629	Lamination collar w/ couplin		A					
L6630	Stainless steel any wrist		A					
L6632	Latex suspension sleeve each		A					
L6635	Lift assist for elbow		A					
L6637	Nudge control elbow lock		A					
L6638	Elec lock on manual pw elbow		A					
L6640	Shoulder abduction joint pai		A					
L6641	Excursion amplifier pulley t		A					
L6642	Excursion amplifier lever ty		A					
L6645	Shoulder flexion-abduction j		A					
L6646	Multipo locking shoulder jnt		A					
L6647	Shoulder lock actuator		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6648	Ext pwrd shlder lock/unlock		A					
L6650	Shoulder universal joint		A					
L6655	Standard control cable extra		A					
L6660	Heavy duty control cable		A					
L6665	Teflon or equal cable lining		A					
L6670	Hook to hand cable adapter		A					
L6672	Harness chest/shlder saddle		A					
L6675	Harness figure of 8 sing con		A					
L6676	Harness figure of 8 dual con		A					
L6677	UE triple control harness		A					
L6680	Test sock wrist disart/bel e		A					
L6682	Test sock elbw disart/above		A					
L6684	Test socket shldr disart/tho		A					
L6686	Suction socket		A					
L6687	Frame typ socket bel elbow/w		A					
L6688	Frame typ sock above elb/dis		A					
L6689	Frame typ socket shoulder di		A					
L6690	Frame typ sock interscap-tho		A					
L6691	Removable insert each		A					
L6692	Silicone gel insert or equal		A					
L6693	Lockingelbow forearm cntrbal		A					
L6694	Elbow socket ins use w/lock		A					
L6695	Elbow socket ins use w/o lck		A					
L6696	Cus elbo skt in for con/atyp		A					
L6697	Cus elbo skt in not con/atyp		A					
L6698	Below/above elbow lock mech		A					
L6703	Term dev, passive hand mitt		A					
L6704	Term dev, sport/rec/work att		A					
L6706	Term dev mech hook vol open		A					
L6707	Term dev mech hook vol close		A					
L6708	Term dev mech hand vol open		A					
L6709	Term dev mech hand vol close		A					
L6711	Ped term dev, hook, vol open		A					
L6712	Ped term dev, hook, vol clos		A					
L6713	Ped term dev, hand, vol open		A					
L6714	Ped term dev, hand, vol clos		A					
L6721	Hook/hand, hvy dty, vol open		A					
L6722	Hook/hand, hvy dty, vol clos		A					
L6805	Term dev modifier wrist unit		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6810	Term dev precision pinch dev		A					
L6881	Term dev auto grasp feature		A					
L6882	Microprocessor control uplmb		A					
L6883	Replc sockt below e/w disa		A					
L6884	Replc sockt above elbow disa		A					
L6885	Replc sockt shldr dis/interc		A					
L6890	Prefab glove for term device		A					
L6895	Custom glove for term device		A					
L6900	Hand restorat thumb/1 finger		A					
L6905	Hand restoration multiple fi		A					
L6910	Hand restoration no fingers		A					
L6915	Hand restoration replacmnt g		A					
L6920	Wrist disarticul switch ctrl		A					
L6925	Wrist disart myoelectronic c		A					
L6930	Below elbow switch control		A					
L6935	Below elbow myoelectronic ct		A					
L6940	Elbow disarticulation switch		A					
L6945	Elbow disart myoelectronic c		A					
L6950	Above elbow switch control		A					
L6955	Above elbow myoelectronic ct		A					
L6960	Shldr disartic switch contro		A					
L6965	Shldr disartic myoelectronic		A					
L6970	Interscapular-thor switch ct		A					
L6975	Interscap-thor myoelectronic		A					
L7007	Adult electric hand		A					
L7008	Pediatric electric hand		A					
L7009	Adult electric hook		A					
L7040	Prehensile actuator		A					
L7045	Pediatric electric hook		A					
L7170	Electronic elbow hosmer swit		A					
L7180	Electronic elbow sequential		A					
L7181	Electronic elbo simultaneous		A					
L7185	Electron elbow adolescent sw		A					
L7186	Electron elbow child switch		A					
L7190	Elbow adolescent myoelectron		A					
L7191	Elbow child myoelectronic ct		A					
L7260	Electron wrist rotator otto		A					
L7261	Electron wrist rotator utah		A					
L7266	Servo control steeper or equ		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L7272	Analogue control unb or equa		A					
L7274	Proportional ctl 12 volt uta		A					
L7360	Six volt bat otto bock/eq ea		A					
L7362	Battery chrgr six volt otto		A					
L7364	Twelve volt battery utah/equ		A					
L7366	Battery chrgr 12 volt utah/e		A					
L7367	Replacemnt lithium ionbatter		A					
L7368	Lithium ion battery charger		A					
L7400	Add UE prost be/wd, ultlite		A					
L7401	Add UE prost a/e ultlite mat		A					
L7402	Add UE prost s/d ultlite mat		A					
L7403	Add UE prost b/e acrylic		A					
L7404	Add UE prost a/e acrylic		A					
L7405	Add UE prost s/d acrylic		A					
L7499	Upper extremity prosthes NOS		A					
L7500	Prosthetic dvc repair hourly		A					
L7510	Prosthetic device repair rep		A					
L7520	Repair prosthesis per 15 min		A					
L7600	Prosthetic donning sleeve		E					
L7900	Male vacuum erection system		A					
L8000	Mastectomy bra		A					
L8001	Breast prosthesis bra & form		A					
L8002	Brst prsth bra & bilat form		A					
L8010	Mastectomy sleeve		A					
L8015	Ext breastprosthesis garment		A					
L8020	Mastectomy form		A					
L8030	Breast prosthes w/o adhesive		A					
L8031	Breast prosthesis w adhesive		A					
L8032	Reusable nipple prosthesis		A					
L8035	Custom breast prosthesis		A					
L8039	Breast prosthesis NOS		A					
L8040	Nasal prosthesis		A					
L8041	Midfacial prosthesis		A					
L8042	Orbital prosthesis		A					
L8043	Upper facial prosthesis		A					
L8044	Hemi-facial prosthesis		A					
L8045	Auricular prosthesis		A					
L8046	Partial facial prosthesis		A					
L8047	Nasal septal prosthesis		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8048	Unspec maxillofacial prosth		A					
L8049	Repair maxillofacial prosth		A					
L8300	Truss single w/ standard pad		A					
L8310	Truss double w/ standard pad		A					
L8320	Truss addition to std pad wa		A					
L8330	Truss add to std pad scrotal		A					
L8400	Sheath below knee		A					
L8410	Sheath above knee		A					
L8415	Sheath upper limb		A					
L8417	Pros sheath/sock w gel cushn		A					
L8420	Prosthetic sock multi ply BK		A					
L8430	Prosthetic sock multi ply AK		A					
L8435	Pros sock multi ply upper lm		A					
L8440	Shrinker below knee		A					
L8460	Shrinker above knee		A					
L8465	Shrinker upper limb		A					
L8470	Pros sock single ply BK		A					
L8480	Pros sock single ply AK		A					
L8485	Pros sock single ply upper l		A					
L8499	Unlisted misc prosthetic ser		A					
L8500	Artificial larynx		A					
L8501	Tracheostomy speaking valve		A					
L8505	Artificial larynx, accessory		A					
L8507	Trach-esoph voice pros pt in		A					
L8509	Trach-esoph voice pros md in		A					
L8510	Voice amplifier		A					
L8511	Indwelling trach insert		A					
L8512	Gel cap for trach voice pros		A					
L8513	Trach pros cleaning device		A					
L8514	Repl trach puncture dilator		A					
L8515	Gel cap app device for trach		A					
L8600	Implant breast silicone/eq		N					
L8603	Collagen imp urinary 2.5 ml		N					
L8604	Dextranomer/hyaluronic acid		N					
L8606	Synthetic implnt urinary 1ml		N					
L8609	Artificial cornea		N					
L8610	Ocular implant		N					
L8612	Aqueous shunt prosthesis		N					
L8613	Ossicular implant		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8614	Cochlear device		N					
L8615	Coch implant headset replace		A					
L8616	Coch implant microphone repl		A					
L8617	Coch implant trans coil repl		A					
L8618	Coch implant tran cable repl		A					
L8619	Coch imp ext proc/contr rplc		A					
L8621	Repl zinc air battery		A					
L8622	Repl alkaline battery		A					
L8623	Lith ion batt CID,non-earlvl		A					
L8624	Lith ion batt CID, ear level		A					
L8627	CID ext speech process repl		A					
L8628	CID ext controller repl		A					
L8629	CID transmit coil and cable		A					
L8630	Metacarpophalangeal implant		N					
L8631	MCP joint repl 2 pc or more		N					
L8641	Metatarsal joint implant		N					
L8642	Hallux implant		N					
L8658	Interphalangeal joint spacer		N					
L8659	Interphalangeal joint repl		N					
L8670	Vascular graft, synthetic		N					
L8680	Implt neurostim elctr each		N					
L8681	Pt prgrm for implt neurostim		A					
L8682	Implt neurostim radiofq rec		N					
L8683	Radiofq trsmtr for implt neu		A					
L8684	Radiof trsmtr implt scrl neu		A					
L8685	Implt nrostm pls gen sng rec		N					
L8686	Implt nrostm pls gen sng non		N					
L8687	Implt nrostm pls gen dua rec		N					
L8688	Implt nrostm pls gen dua non		N					
L8689	External recharg sys intern		A					
L8690	Aud osseo dev, int/ext comp		N					
L8691	Osseointegrated snd proc rpl		A					
L8692	Non-osseointegrated snd proc		E					
L8693	Aud osseo dev, abutment	NI	A					
L8695	External recharg sys extern		A					
L8699	Prosthetic implant NOS		N					
L9900	O&P supply/accessory/service		N					
M0064	Visit for drug monitoring		Q3	0607	1.8654	$128.48	.	$25.70
M0075	Cellular therapy		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
M0076	Prolotherapy		E					
M0100	Intragastric hypothermia		E					
M0300	IV chelationtherapy		E					
M0301	Fabric wrapping of aneurysm		E					
P2028	Cephalin floculation test		A					
P2029	Congo red blood test		A					
P2031	Hair analysis		E					
P2033	Blood thymol turbidity		A					
P2038	Blood mucoprotein		A					
P3000	Screen pap by tech w md supv		A					
P3001	Screening pap smear by phys		B					
P7001	Culture bacterial urine		E					
P9010	Whole blood for transfusion		R	0950	2.9448	$202.83	.	$40.57
P9011	Blood split unit		R	0967	3.0703	$211.47	.	$42.30
P9012	Cryoprecipitate each unit		R	0952	0.7330	$50.49	.	$10.10
P9016	RBC leukocytes reduced		R	0954	2.8292	$194.86	.	$38.98
P9017	Plasma 1 donor frz w/in 8 hr		R	9508	1.1521	$79.35	.	$15.87
P9019	Platelets, each unit		R	0957	1.0780	$74.25	.	$14.85
P9020	Plaelet rich plasma unit		R	0958	2.0756	$142.96	.	$28.60
P9021	Red blood cells unit		R	0959	2.2405	$154.32	.	$30.87
P9022	Washed red blood cells unit		R	0960	4.1493	$285.79	.	$57.16
P9023	Frozen plasma, pooled, sd		R	0949	0.8848	$60.94	.	$12.19
P9031	Platelets leukocytes reduced		R	1013	1.6045	$110.51	.	$22.11
P9032	Platelets, irradiated		R	9500	2.1010	$144.71	.	$28.95
P9033	Platelets leukoreduced irrad		R	0968	2.0647	$142.21	.	$28.45
P9034	Platelets, pheresis		R	9507	6.6574	$458.54	.	$91.71
P9035	Platelet pheres leukoreduced		R	9501	7.8186	$538.51	.	$107.71
P9036	Platelet pheresis irradiated		R	9502	6.5749	$452.85	.	$90.57
P9037	Plate pheres leukoredu irrad		R	1019	9.5146	$655.33	.	$131.07
P9038	RBC irradiated		R	9505	3.2550	$224.19	.	$44.84
P9039	RBC deglycerolized		R	9504	5.2989	$364.97	.	$73.00
P9040	RBC leukoreduced irradiated		R	0969	3.5983	$247.84	.	$49.57
P9041	Albumin (human),5%, 50ml		K	0961	.	$20.37	.	$4.08
P9043	Plasma protein fract,5%,50ml		R	0956	0.4019	$27.68	.	$5.54
P9044	Cryoprecipitatereducedplasma		R	1009	1.2488	$86.01	.	$17.21
P9045	Albumin (human), 5%, 250 ml		K	0963	.	$67.07	.	$13.42
P9046	Albumin (human), 25%, 20 ml		K	0964	.	$29.16	.	$5.84
P9047	Albumin (human), 25%, 50ml		K	0965	.	$70.39	.	$14.08
P9048	Plasmaprotein fract,5%,250ml		R	0966	1.4345	$98.80	.	$19.76

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
P9050	Granulocytes, pheresis unit		R	9506	21.8976	$1,508.22	.	$301.65
P9051	Blood, l/r, cmv-neg		R	1010	2.6086	$179.67	.	$35.94
P9052	Platelets, hla-m, l/r, unit		R	1011	11.8651	$817.22	.	$163.45
P9053	Plt, pher, l/r cmv-neg, irr		R	1020	9.0642	$624.31	.	$124.87
P9054	Blood, l/r, froz/degly/wash		R	1016	1.6688	$114.94	.	$22.99
P9055	Plt, aph/pher, l/r, cmv-neg		R	1017	6.4027	$440.99	.	$88.20
P9056	Blood, l/r, irradiated		R	1018	2.4995	$172.16	.	$34.44
P9057	RBC, frz/deg/wsh, l/r, irrad		R	1021	4.3260	$297.96	.	$59.60
P9058	RBC, l/r, cmv-neg, irrad		R	1022	4.1488	$285.75	.	$57.15
P9059	Plasma, frz between 8-24hour		R	0955	1.0620	$73.15	.	$14.63
P9060	Fr frz plasma donor retested		R	9503	1.0328	$71.14	.	$14.23
P9603	One-way allow prorated miles		A					
P9604	One-way allow prorated trip		A					
P9612	Catheterize for urine spec		A					
P9615	Urine specimen collect mult		N					
Q0035	Cardiokymography		X	0100	2.5904	$178.42	$41.44	$35.69
Q0081	Infusion ther other than che		B					
Q0083	Chemo by other than infusion		B					
Q0084	Chemotherapy by infusion		B					
Q0085	Chemo by both infusion and o		B					
Q0091	Obtaining screen pap smear		T	0191	0.1446	$9.96	$0.00	$0.00
Q0092	Set up port xray equipment		N					
Q0111	Wet mounts/ w preparations		A					
Q0112	Potassium hydroxide preps		A					
Q0113	Pinworm examinations		A					
Q0114	Fern test		A					
Q0115	Post-coital mucous exam		A					
Q0138	Ferumoxytol, non-esrd		G	1297	.	$0.77	.	$0.15
Q0139	Ferumoxytol, esrd use		A					
Q0144	Azithromycin dihydrate, oral		E					
Q0163	Diphenhydramine HCl 50mg		N					
Q0164	Prochlorperazine maleate 5mg		N					
Q0165	Prochlorperazine maleate10mg		N					
Q0166	Granisetron hcl 1 mg oral		N					
Q0167	Dronabinol 2.5mg oral		N					
Q0168	Dronabinol 5mg oral		N					
Q0169	Promethazine HCl 12.5mg oral		N					
Q0170	Promethazine HCl 25 mg oral		N					
Q0171	Chlorpromazine HCl 10mg oral		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q0172	Chlorpromazine HCl 25mg oral		N					
Q0173	Trimethobenzamide HCl 250mg		N					
Q0174	Thiethylperazine maleate10mg	CH	E					
Q0175	Perphenazine 4mg oral		N					
Q0176	Perphenazine 8mg oral		N					
Q0177	Hydroxyzine pamoate 25mg		N					
Q0178	Hydroxyzine pamoate 50mg		N					
Q0179	Ondansetron hcl 8 mg oral		N					
Q0180	Dolasetron mesylate oral		N					
Q0181	Unspecified oral anti-emetic		E					
Q0478	Power adapter, combo vad	NI	A					
Q0479	Power module combo vad, rep	NI	A					
Q0480	Driver pneumatic vad, rep		A					
Q0481	Microprcsr cu elec vad, rep		A					
Q0482	Microprcsr cu combo vad, rep		A					
Q0483	Monitor elec vad, rep		A					
Q0484	Monitor elec or comb vad rep		A					
Q0485	Monitor cable elec vad, rep		A					
Q0486	Mon cable elec/pneum vad rep		A					
Q0487	Leads any type vad, rep only		A					
Q0488	Pwr pack base elec vad, rep		A					
Q0489	Pwr pck base combo vad, rep		A					
Q0490	Emr pwr source elec vad, rep		A					
Q0491	Emr pwr source combo vad rep		A					
Q0492	Emr pwr cbl elec vad, rep		A					
Q0493	Emr pwr cbl combo vad, rep		A					
Q0494	Emr hd pmp elec/combo, rep		A					
Q0495	Charger elec/combo vad, rep		A					
Q0496	Battery elec/combo vad, rep		A					
Q0497	Bat clps elec/comb vad, rep		A					
Q0498	Holster elec/combo vad, rep		A					
Q0499	Belt/vest elec/combo vad rep		A					
Q0500	Filters elec/combo vad, rep		A					
Q0501	Shwr cov elec/combo vad, rep		A					
Q0502	Mobility cart pneum vad, rep		A					
Q0503	Battery pneum vad replacemnt		A					
Q0504	Pwr adpt pneum vad, rep veh		A					
Q0505	Miscl supply/accessory vad		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q0506	Lith-ion batt elec/pneum VAD		A					
Q0510	Dispens fee immunosupressive		B					
Q0511	Sup fee antiem,antica,immuno		B					
Q0512	Px sup fee anti-can sub pres		B					
Q0513	Disp fee inhal drugs/30 days		B					
Q0514	Disp fee inhal drugs/90 days		B					
Q0515	Sermorelin acetate injection		K	3050	.	$1.78	.	$0.36
Q1003	Ntiol category 3		N					
Q1004	Ntiol category 4		E					
Q1005	Ntiol category 5		E					
Q2004	Bladder calculi irrig sol	CH	N					
Q2009	Fosphenytoin inj PE		N					
Q2017	Teniposide, 50 mg		K	7035	.	$320.61	.	$64.13
Q2025	Oral fludarabine phosphate	CH	D					
Q2026	Radiesse injection		B					
Q2027	Sculptra injection		B					
Q2035	Afluria vacc, 3 yrs & >, im	NI	L					
Q2036	Flulaval vacc, 3 yrs & >, im	NI	L					
Q2037	Fluvirin vacc, 3 yrs & >, im	NI	L					
Q2038	Fluzone vacc, 3 yrs & >, im	NI	L					
Q2039	NOS flu vacc, 3 yrs & >, im	NI	L					
Q3001	Brachytherapy Radioelements		B					
Q3014	Telehealth facility fee		A					
Q3025	IM inj interferon beta 1-a		K	9022	.	$212.28	.	$42.46
Q3026	Subc inj interferon beta-1a		E					
Q3031	Collagen skin test		N					
Q4001	Cast sup body cast plaster		B					
Q4002	Cast sup body cast fiberglas		B					
Q4003	Cast sup shoulder cast plstr		B					
Q4004	Cast sup shoulder cast fbrgl		B					
Q4005	Cast sup long arm adult plst		B					
Q4006	Cast sup long arm adult fbrg		B					
Q4007	Cast sup long arm ped plster		B					
Q4008	Cast sup long arm ped fbrgls		B					
Q4009	Cast sup sht arm adult plstr		B					
Q4010	Cast sup sht arm adult fbrgl		B					
Q4011	Cast sup sht arm ped plaster		B					
Q4012	Cast sup sht arm ped fbrglas		B					
Q4013	Cast sup gauntlet plaster		B					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4014	Cast sup gauntlet fiberglass		B					
Q4015	Cast sup gauntlet ped plster		B					
Q4016	Cast sup gauntlet ped fbrgls		B					
Q4017	Cast sup lng arm splint plst		B					
Q4018	Cast sup lng arm splint fbrg		B					
Q4019	Cast sup lng arm splnt ped p		B					
Q4020	Cast sup lng arm splnt ped f		B					
Q4021	Cast sup sht arm splint plst		B					
Q4022	Cast sup sht arm splint fbrg		B					
Q4023	Cast sup sht arm splnt ped p		B					
Q4024	Cast sup sht arm splnt ped f		B					
Q4025	Cast sup hip spica plaster		B					
Q4026	Cast sup hip spica fiberglas		B					
Q4027	Cast sup hip spica ped plstr		B					
Q4028	Cast sup hip spica ped fbrgl		B					
Q4029	Cast sup long leg plaster		B					
Q4030	Cast sup long leg fiberglass		B					
Q4031	Cast sup lng leg ped plaster		B					
Q4032	Cast sup lng leg ped fbrgls		B					
Q4033	Cast sup lng leg cylinder pl		B					
Q4034	Cast sup lng leg cylinder fb		B					
Q4035	Cast sup lngleg cylndr ped p		B					
Q4036	Cast sup lngleg cylndr ped f		B					
Q4037	Cast sup shrt leg plaster		B					
Q4038	Cast sup shrt leg fiberglass		B					
Q4039	Cast sup shrt leg ped plster		B					
Q4040	Cast sup shrt leg ped fbrgls		B					
Q4041	Cast sup lng leg splnt plstr		B					
Q4042	Cast sup lng leg splnt fbrgl		B					
Q4043	Cast sup lng leg splnt ped p		B					
Q4044	Cast sup lng leg splnt ped f		B					
Q4045	Cast sup sht leg splnt plstr		B					
Q4046	Cast sup sht leg splnt fbrgl		B					
Q4047	Cast sup sht leg splnt ped p		B					
Q4048	Cast sup sht leg splnt ped f		B					
Q4049	Finger splint, static		B					
Q4050	Cast supplies unlisted		B					
Q4051	Splint supplies misc		B					
Q4074	Iloprost non-comp unit dose		Y					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4081	Epoetin alfa, 100 units ESRD		A					
Q4082	Drug/bio NOC part B drug CAP		B					
Q4100	Skin substitute, NOS		N					
Q4101	Apligraf		K	1240	.	$33.77	.	$6.76
Q4102	Oasis wound matrix		K	1241	.	$4.38	.	$0.88
Q4103	Oasis burn matrix		K	1242	.	$4.38	.	$0.88
Q4104	Integra BMWD		K	1243	.	$14.91	.	$2.99
Q4105	Integra DRT		K	1244	.	$10.13	.	$2.03
Q4106	Dermagraft		K	1245	.	$39.73	.	$7.95
Q4107	Graftjacket		K	1246	.	$94.23	.	$18.85
Q4108	Integra matrix		K	1247	.	$19.04	.	$3.81
Q4109	Tissuemend skin sub	CH	D					
Q4110	Primatrix		K	1248	.	$34.71	.	$6.95
Q4111	Gammagraft		K	1252	.	$7.03	.	$1.41
Q4112	Cymetra injectable		K	1249	.	$350.04	.	$70.01
Q4113	Graftjacket xpress		K	1250	.	$350.04	.	$70.01
Q4114	Integra flowable wound matri	CH	K	1251	.	$948.50	.	$189.70
Q4115	Alloskin		K	1287	.	$6.63	.	$1.33
Q4116	Alloderm		K	1270	.	$32.31	.	$6.47
Q4117	Hyalomatrix	NI	E					
Q4118	Matristem micromatrix	NI	K	1342	.	$1.80	.	$0.36
Q4119	Matristem wound matrix	NI	E					
Q4120	Matristem burn matrix	NI	E					
Q4121	Theraskin	NI	K	1345	.	$21.27	.	$4.26
Q5001	Hospice in patient home		B					
Q5002	Hospice in assisted living		B					
Q5003	Hospice in LT/non-skilled NF		B					
Q5004	Hospice in SNF		B					
Q5005	Hospice, inpatient hospital		B					
Q5006	Hospice in hospice facility		B					
Q5007	Hospice in LTCH		B					
Q5008	Hospice in inpatient psych		B					
Q5009	Hospice care, NOS		B					
Q5010	Hospice home care in hospice		B					
Q9951	LOCM >= 400 mg/ml iodine,1ml		N					
Q9953	Inj Fe-based MR contrast,1ml		N					
Q9954	Oral MR contrast, 100 ml		N					
Q9955	Inj perflexane lip micros,ml		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q9956	Inj octafluoropropane mic,ml		N					
Q9957	Inj perflutren lip micros,ml		N					
Q9958	HOCM <=149 mg/ml iodine, 1ml		N					
Q9959	HOCM 150-199mg/ml iodine,1ml		N					
Q9960	HOCM 200-249mg/ml iodine,1ml		N					
Q9961	HOCM 250-299mg/ml iodine,1ml		N					
Q9962	HOCM 300-349mg/ml iodine,1ml		N					
Q9963	HOCM 350-399mg/ml iodine,1ml		N					
Q9964	HOCM>= 400mg/ml iodine, 1ml		N					
Q9965	LOCM 100-199mg/ml iodine,1ml		N					
Q9966	LOCM 200-299mg/ml iodine,1ml		N					
Q9967	LOCM 300-399mg/ml iodine,1ml		N					
Q9968	Visualization adjunct		K	1288	.	$1.44	.	$0.29
R0070	Transport portable x-ray		B					
R0075	Transport port x-ray multipl		B					
R0076	Transport portable EKG		B					
V2020	Vision svcs frames purchases		A					
V2025	Eyeglasses delux frames		E					
V2100	Lens spher single plano 4.00		A					
V2101	Single visn sphere 4.12-7.00		A					
V2102	Singl visn sphere 7.12-20.00		A					
V2103	Spherocylindr 4.00d/12-2.00d		A					
V2104	Spherocylindr 4.00d/2.12-4d		A					
V2105	Spherocylinder 4.00d/4.25-6d		A					
V2106	Spherocylinder 4.00d/>6.00d		A					
V2107	Spherocylinder 4.25d/12-2d		A					
V2108	Spherocylinder 4.25d/2.12-4d		A					
V2109	Spherocylinder 4.25d/4.25-6d		A					
V2110	Spherocylinder 4.25d/over 6d		A					
V2111	Spherocylindr 7.25d/.25-2.25		A					
V2112	Spherocylindr 7.25d/2.25-4d		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2113	Spherocylindr 7.25d/4.25-6d		A					
V2114	Spherocylinder over 12.00d		A					
V2115	Lens lenticular bifocal		A					
V2118	Lens aniseikonic single		A					
V2121	Lenticular lens, single		A					
V2199	Lens single vision not oth c		A					
V2200	Lens spher bifoc plano 4.00d		A					
V2201	Lens sphere bifocal 4.12-7.0		A					
V2202	Lens sphere bifocal 7.12-20.		A					
V2203	Lens sphcyl bifocal 4.00d/.1		A					
V2204	Lens sphcy bifocal 4.00d/2.1		A					
V2205	Lens sphcy bifocal 4.00d/4.2		A					
V2206	Lens sphcy bifocal 4.00d/ove		A					
V2207	Lens sphcy bifocal 4.25-7d/.		A					
V2208	Lens sphcy bifocal 4.25-7/2.		A					
V2209	Lens sphcy bifocal 4.25-7/4.		A					
V2210	Lens sphcy bifocal 4.25-7/ov		A					
V2211	Lens sphcy bifo 7.25-12/.25-		A					
V2212	Lens sphcyl bifo 7.25-12/2.2		A					
V2213	Lens sphcyl bifo 7.25-12/4.2		A					
V2214	Lens sphcyl bifocal over 12.		A					
V2215	Lens lenticular bifocal		A					
V2218	Lens aniseikonic bifocal		A					
V2219	Lens bifocal seg width over		A					
V2220	Lens bifocal add over 3.25d		A					
V2221	Lenticular lens, bifocal		A					
V2299	Lens bifocal speciality		A					
V2300	Lens sphere trifocal 4.00d		A					
V2301	Lens sphere trifocal 4.12-7.		A					
V2302	Lens sphere trifocal 7.12-20		A					
V2303	Lens sphcy trifocal 4.0/.12-		A					
V2304	Lens sphcy trifocal 4.0/2.25		A					
V2305	Lens sphcy trifocal 4.0/4.25		A					
V2306	Lens sphcyl trifocal 4.00/>6		A					
V2307	Lens sphcy trifocal 4.25-7/.		A					
V2308	Lens sphc trifocal 4.25-7/2.		A					
V2309	Lens sphc trifocal 4.25-7/4.		A					
V2310	Lens sphc trifocal 4.25-7/>6		A					
V2311	Lens sphc trifo 7.25-12/.25-		A					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2312	Lens sphc trifo 7.25-12/2.25		A					
V2313	Lens sphc trifo 7.25-12/4.25		A					
V2314	Lens sphcyl trifocal over 12		A					
V2315	Lens lenticular trifocal		A					
V2318	Lens aniseikonic trifocal		A					
V2319	Lens trifocal seg width > 28		A					
V2320	Lens trifocal add over 3.25d		A					
V2321	Lenticular lens, trifocal		A					
V2399	Lens trifocal speciality		A					
V2410	Lens variab asphericity sing		A					
V2430	Lens variable asphericity bi		A					
V2499	Variable asphericity lens		A					
V2500	Contact lens pmma spherical		A					
V2501	Cntct lens pmma-toric/prism		A					
V2502	Contact lens pmma bifocal		A					
V2503	Cntct lens pmma color vision		A					
V2510	Cntct gas permeable sphericl		A					
V2511	Cntct toric prism ballast		A					
V2512	Cntct lens gas permbl bifocl		A					
V2513	Contact lens extended wear		A					
V2520	Contact lens hydrophilic		A					
V2521	Cntct lens hydrophilic toric		A					
V2522	Cntct lens hydrophil bifocl		A					
V2523	Cntct lens hydrophil extend		A					
V2530	Contact lens gas impermeable		A					
V2531	Contact lens gas permeable		A					
V2599	Contact lens/es other type		A					
V2600	Hand held low vision aids		A					
V2610	Single lens spectacle mount		A					
V2615	Telescop/othr compound lens		A					
V2623	Plastic eye prosth custom		A					
V2624	Polishing artifical eye		A					
V2625	Enlargemnt of eye prosthesis		A					
V2626	Reduction of eye prosthesis		A					
V2627	Scleral cover shell		A					
V2628	Fabrication & fitting		A					
V2629	Prosthetic eye other type		A					
V2630	Anter chamber intraocul lens		N					
V2631	Iris support intraoclr lens		N					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2632	Post chmbr intraocular lens		N					
V2700	Balance lens		A					
V2702	Deluxe lens feature		E					
V2710	Glass/plastic slab off prism		A					
V2715	Prism lens/es		A					
V2718	Fresnell prism press-on lens		A					
V2730	Special base curve		A					
V2744	Tint photochromatic lens/es		A					
V2745	Tint, any color/solid/grad		A					
V2750	Anti-reflective coating		A					
V2755	UV lens/es		A					
V2756	Eye glass case		E					
V2760	Scratch resistant coating		A					
V2761	Mirror coating		B					
V2762	Polarization, any lens		A					
V2770	Occluder lens/es		A					
V2780	Oversize lens/es		A					
V2781	Progressive lens per lens		B					
V2782	Lens, 1.54-1.65 p/1.60-1.79g		A					
V2783	Lens, >= 1.66 p/>=1.80 g		A					
V2784	Lens polycarb or equal		A					
V2785	Corneal tissue processing		F					
V2786	Occupational multifocal lens		A					
V2787	Astigmatism-correct function		E					
V2788	Presbyopia-correct function		E					
V2790	Amniotic membrane		N					
V2797	Vis item/svc in other code		A					
V2799	Miscellaneous vision service		A					
V5008	Hearing screening		E					
V5010	Assessment for hearing aid		E					
V5011	Hearing aid fitting/checking		E					
V5014	Hearing aid repair/modifying		E					
V5020	Conformity evaluation		E					
V5030	Body-worn hearing aid air		E					
V5040	Body-worn hearing aid bone		E					
V5050	Hearing aid monaural in ear		E					
V5060	Behind ear hearing aid		E					
V5070	Glasses air conduction		E					
V5080	Glasses bone conduction		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V5090	Hearing aid dispensing fee		E					
V5095	Implant mid ear hearing pros		E					
V5100	Body-worn bilat hearing aid		E					
V5110	Hearing aid dispensing fee		E					
V5120	Body-worn binaur hearing aid		E					
V5130	In ear binaural hearing aid		E					
V5140	Behind ear binaur hearing ai		E					
V5150	Glasses binaural hearing aid		E					
V5160	Dispensing fee binaural		E					
V5170	Within ear cros hearing aid		E					
V5180	Behind ear cros hearing aid		E					
V5190	Glasses cros hearing aid		E					
V5200	Cros hearing aid dispens fee		E					
V5210	In ear bicros hearing aid		E					
V5220	Behind ear bicros hearing ai		E					
V5230	Glasses bicros hearing aid		E					
V5240	Dispensing fee bicros		E					
V5241	Dispensing fee, monaural		E					
V5242	Hearing aid, monaural, cic		E					
V5243	Hearing aid, monaural, itc		E					
V5244	Hearing aid, prog, mon, cic		E					
V5245	Hearing aid, prog, mon, itc		E					
V5246	Hearing aid, prog, mon, ite		E					
V5247	Hearing aid, prog, mon, bte		E					
V5248	Hearing aid, binaural, cic		E					
V5249	Hearing aid, binaural, itc		E					
V5250	Hearing aid, prog, bin, cic		E					
V5251	Hearing aid, prog, bin, itc		E					
V5252	Hearing aid, prog, bin, ite		E					
V5253	Hearing aid, prog, bin, bte		E					
V5254	Hearing id, digit, mon, cic		E					
V5255	Hearing aid, digit, mon, itc		E					
V5256	Hearing aid, digit, mon, ite		E					
V5257	Hearing aid, digit, mon, bte		E					
V5258	Hearing aid, digit, bin, cic		E					
V5259	Hearing aid, digit, bin, itc		E					
V5260	Hearing aid, digit, bin, ite		E					
V5261	Hearing aid, digit, bin, bte		E					
V5262	Hearing aid, disp, monaural		E					

ADDENDUM B.—OPPS PAYMENT BY HCPCS CODE FOR CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V5263	Hearing aid, disp, binaural		E					
V5264	Ear mold/insert		E					
V5265	Ear mold/insert, disp		E					
V5266	Battery for hearing device		E					
V5267	Hearing aid supply/accessory		E					
V5268	ALD Telephone Amplifier		E					
V5269	Alerting device, any type		E					
V5270	ALD, TV amplifier, any type		E					
V5271	ALD, TV caption decoder		E					
V5272	Tdd		E					
V5273	ALD for cochlear implant		E					
V5274	ALD unspecified		E					
V5275	Ear impression		E					
V5298	Hearing aid noc		E					
V5299	Hearing service		B					
V5336	Repair communication device		E					
V5362	Speech screening		E					
V5363	Language screening		E					
V5364	Dysphagia screening		E					

ADDENDUM BB.—FINAL ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)					
HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
0042T	Ct perfusion w/contrast cbf		N1		
0073T	Delivery comp imrt		Z2	5.8777	$246.50
0126T	Chd risk imt study		N1		
0159T	Cad breast mri		N1		
0174T	Cad cxr with interp		N1		

ADDENDUM BB.—FINAL ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)					
HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
0175T	Cad cxr remote		N1		
0182T	Hdr elect brachytherapy		Z2	9.3901	$393.81
0185T	Comptr probability analysis		N1		
70010	Contrast x-ray of brain		N1		
70015	Contrast x-ray of brain		N1		
70030	X-ray eye for foreign body		Z3		$15.31
70100	X-ray exam of jaw		Z3		$18.12
70110	X-ray exam of jaw		Z3		$20.42
70120	X-ray exam of mastoids		Z3		$19.65
70130	X-ray exam of mastoids		Z2	0.6041	$25.34
70134	X-ray exam of middle ear		Z3		$22.46
70140	X-ray exam of facial bones		Z3		$15.31
70150	X-ray exam of facial bones		Z3		$22.71
70160	X-ray exam of nasal bones		Z3		$18.63
70170	X-ray exam of tear duct		N1		
70190	X-ray exam of eye sockets		Z3		$19.14
70200	X-ray exam of eye sockets		Z3		$22.71
70210	X-ray exam of sinuses		Z3		$16.59
70220	X-ray exam of sinuses		Z3		$20.16
70240	X-ray exam pituitary saddle		Z3		$15.31
70250	X-ray exam of skull		Z3		$18.63
70260	X-ray exam of skull		Z3		$23.22
70300	X-ray exam of teeth		Z3		$6.64
70310	X-ray exam of teeth		Z2	0.4089	$17.15
70320	Full mouth x-ray of teeth		Z2	0.4089	$17.15
70328	X-ray exam of jaw joint		Z3		$16.33
70330	X-ray exam of jaw joints		Z2	0.6041	$25.34
70332	X-ray exam of jaw joint		N1		
70336	Magnetic image jaw joint		Z2	4.5995	$192.90
70350	X-ray head for orthodontia		Z3		$8.93
70355	Panoramic x-ray of jaws		Z3		$8.17
70360	X-ray exam of neck		Z3		$14.29
70370	Throat x-ray & fluoroscopy		Z2	1.1199	$46.97
70371	Speech evaluation complex		Z3		$40.32
70373	Contrast x-ray of larynx		N1		
70380	X-ray exam of salivary gland		Z3		$22.97

ADDENDUM BB.—FINAL ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
70390	X-ray exam of salivary duct		N1		
70450	Ct head/brain w/o dye		Z2	2.6	$109.04
70460	Ct head/brain w/dye		Z3		$151.60
70470	Ct head/brain w/o & w/dye		Z3		$186.56
70480	Ct orbit/ear/fossa w/o dye		Z2	2.6	$109.04
70481	Ct orbit/ear/fossa w/dye		Z2	4.0212	$168.65
70482	Ct orbit/ear/fossa w/o&w/dye		Z2	4.483	$188.01
70486	Ct maxillofacial w/o dye		Z2	2.6	$109.04
70487	Ct maxillofacial w/dye		Z2	4.0212	$168.65
70488	Ct maxillofacial w/o & w/dye		Z2	4.483	$188.01
70490	Ct soft tissue neck w/o dye		Z2	2.6	$109.04
70491	Ct soft tissue neck w/dye		Z2	4.0212	$168.65
70492	Ct sft tsue nck w/o & w/dye		Z2	4.483	$188.01
70496	Ct angiography head		Z2	4.5406	$190.43
70498	Ct angiography neck		Z2	4.5406	$190.43
70540	Mri orbit/face/neck w/o dye		Z2	4.5995	$192.90
70542	Mri orbit/face/neck w/dye		Z2	5.861	$245.80
70543	Mri orbt/fac/nck w/o & w/dye		Z2	7.1569	$300.15
70544	Mr angiography head w/o dye		Z2	4.5995	$192.90
70545	Mr angiography head w/dye		Z2	5.861	$245.80
70546	Mr angiograph head w/o&w/dye		Z2	7.1569	$300.15
70547	Mr angiography neck w/o dye		Z2	4.5995	$192.90
70548	Mr angiography neck w/dye		Z2	5.861	$245.80
70549	Mr angiograph neck w/o&w/dye		Z2	7.1569	$300.15
70551	Mri brain w/o dye		Z2	4.5995	$192.90
70552	Mri brain w/dye		Z2	5.861	$245.80
70553	Mri brain w/o & w/dye		Z2	7.1569	$300.15
70554	Fmri brain by tech		Z2	4.5995	$192.90
70555	Fmri brain by phys/psych		Z2	4.5995	$192.90
70557	Mri brain w/o dye		Z2	4.5995	$192.90
70558	Mri brain w/dye		Z2	5.861	$245.80
70559	Mri brain w/o & w/dye		Z2	7.1569	$300.15
71010	Chest x-ray		Z3		$11.23
71015	Chest x-ray		Z3		$14.80
71020	Chest x-ray		Z3		$15.06
71021	Chest x-ray		Z3		$18.63

ADDENDUM BB.—FINAL ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
71022	Chest x-ray		Z3		$23.48
71023	Chest x-ray and fluoroscopy		Z3		$38.03
71030	Chest x-ray		Z3		$23.48
71034	Chest x-ray and fluoroscopy		Z2	1.1199	$46.97
71035	Chest x-ray		Z3		$19.91
71040	Contrast x-ray of bronchi		N1		
71060	Contrast x-ray of bronchi		N1		
71090	X-ray & pacemaker insertion		N1		
71100	X-ray exam of ribs		Z3		$16.33
71101	X-ray exam of ribs/chest		Z3		$19.91
71110	X-ray exam of ribs		Z3		$20.67
71111	X-ray exam of ribs/chest		Z3		$28.07
71120	X-ray exam of breastbone		Z3		$16.59
71130	X-ray exam of breastbone		Z3		$19.91
71250	Ct thorax w/o dye		Z2	2.6	$109.04
71260	Ct thorax w/dye		Z2	4.0212	$168.65
71270	Ct thorax w/o & w/dye		Z2	4.483	$188.01
71275	Ct angiography chest		Z2	4.5406	$190.43
71550	Mri chest w/o dye		Z2	4.5995	$192.90
71551	Mri chest w/dye		Z2	5.861	$245.80
71552	Mri chest w/o & w/dye		Z2	7.1569	$300.15
72010	X-ray exam of spine		Z3		$39.05
72020	X-ray exam of spine		Z3		$12.00
72040	X-ray exam of neck spine		Z3		$20.42
72050	X-ray exam of neck spine		Z3		$28.07
72052	X-ray exam of neck spine		Z3		$37.01
72069	X-ray exam of trunk spine		Z3		$19.40
72070	X-ray exam of thoracic spine		Z3		$17.10
72072	X-ray exam of thoracic spine		Z3		$20.42
72074	X-ray exam of thoracic spine		Z2	0.6041	$25.34
72080	X-ray exam of trunk spine		Z3		$18.89
72090	X-ray exam of trunk spine		Z3		$26.03
72100	X-ray exam of lower spine		Z3		$21.95
72110	X-ray exam of lower spine		Z3		$30.12
72114	X-ray exam of lower spine		Z3		$42.11
72120	X-ray exam of lower spine		Z2	0.6041	$25.34

ADDENDUM BB.—FINAL ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
72125	Ct neck spine w/o dye		Z2	2.6	$109.04
72126	Ct neck spine w/dye		Z2	4.0212	$168.65
72127	Ct neck spine w/o & w/dye		Z2	4.483	$188.01
72128	Ct chest spine w/o dye		Z2	2.6	$109.04
72129	Ct chest spine w/dye		Z2	4.0212	$168.65
72130	Ct chest spine w/o & w/dye		Z2	4.483	$188.01
72131	Ct lumbar spine w/o dye		Z2	2.6	$109.04
72132	Ct lumbar spine w/dye		Z2	4.0212	$168.65
72133	Ct lumbar spine w/o & w/dye		Z2	4.483	$188.01
72141	Mri neck spine w/o dye		Z2	4.5995	$192.90
72142	Mri neck spine w/dye		Z2	5.861	$245.80
72146	Mri chest spine w/o dye		Z2	4.5995	$192.90
72147	Mri chest spine w/dye		Z2	5.861	$245.80
72148	Mri lumbar spine w/o dye		Z2	4.5995	$192.90
72149	Mri lumbar spine w/dye		Z2	5.861	$245.80
72156	Mri neck spine w/o & w/dye		Z2	7.1569	$300.15
72157	Mri chest spine w/o & w/dye		Z2	7.1569	$300.15
72158	Mri lumbar spine w/o & w/dye		Z2	7.1569	$300.15
72170	X-ray exam of pelvis		Z3		$13.27
72190	X-ray exam of pelvis		Z3		$22.97
72191	Ct angiograph pelv w/o&w/dye		Z2	4.5406	$190.43
72192	Ct pelvis w/o dye		Z2	2.6	$109.04
72193	Ct pelvis w/dye		Z2	4.0212	$168.65
72194	Ct pelvis w/o & w/dye		Z2	4.483	$188.01
72195	Mri pelvis w/o dye		Z2	4.5995	$192.90
72196	Mri pelvis w/dye		Z2	5.861	$245.80
72197	Mri pelvis w/o & w/dye		Z2	7.1569	$300.15
72200	X-ray exam sacroiliac joints		Z3		$15.82
72202	X-ray exam sacroiliac joints		Z3		$19.14
72220	X-ray exam of tailbone		Z3		$15.57
72240	Contrast x-ray of neck spine		N1		
72255	Contrast x-ray thorax spine		N1		
72265	Contrast x-ray lower spine		N1		
72270	Contrast x-ray spine		N1		
72275	Epidurography		N1		
72285	X-ray c/t spine disk		N1		

ADDENDUM BB.—FINAL ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
72291	Perq verte/sacroplsty fluor		N1		
72292	Perq verte/sacroplsty ct		N1		
72295	X-ray of lower spine disk		N1		
73000	X-ray exam of collar bone		Z3		$15.31
73010	X-ray exam of shoulder blade		Z3		$16.08
73020	X-ray exam of shoulder		Z3		$12.25
73030	X-ray exam of shoulder		Z3		$15.82
73040	Contrast x-ray of shoulder		N1		
73050	X-ray exam of shoulders		Z3		$20.67
73060	X-ray exam of humerus		Z3		$15.57
73070	X-ray exam of elbow		Z3		$15.31
73080	X-ray exam of elbow		Z3		$19.40
73085	Contrast x-ray of elbow		N1		
73090	X-ray exam of forearm		Z3		$14.80
73092	X-ray exam of arm infant		Z3		$17.10
73100	X-ray exam of wrist		Z3		$16.59
73110	X-ray exam of wrist		Z3		$20.93
73115	Contrast x-ray of wrist		N1		
73120	X-ray exam of hand		Z3		$14.80
73130	X-ray exam of hand		Z3		$17.61
73140	X-ray exam of finger(s)		Z3		$18.63
73200	Ct upper extremity w/o dye		Z2	2.6	$109.04
73201	Ct upper extremity w/dye		Z2	4.0212	$168.65
73202	Ct uppr extremity w/o&w/dye		Z2	4.483	$188.01
73206	Ct angio upr extrm w/o&w/dye		Z2	4.5406	$190.43
73218	Mri upper extremity w/o dye		Z2	4.5995	$192.90
73219	Mri upper extremity w/dye		Z2	5.861	$245.80
73220	Mri uppr extremity w/o&w/dye		Z2	7.1569	$300.15
73221	Mri joint upr extrem w/o dye		Z2	4.5995	$192.90
73222	Mri joint upr extrem w/dye		Z2	5.861	$245.80
73223	Mri joint upr extr w/o&w/dye		Z2	7.1569	$300.15
73500	X-ray exam of hip		Z3		$13.02
73510	X-ray exam of hip		Z3		$20.42
73520	X-ray exam of hips		Z3		$20.67
73525	Contrast x-ray of hip		N1		
73530	X-ray exam of hip		N1		

ADDENDUM BB.—FINAL ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
73540	X-ray exam of pelvis & hips		Z3		$22.71
73542	X-ray exam sacroiliac joint		N1		
73550	X-ray exam of thigh		Z3		$14.80
73560	X-ray exam of knee 1 or 2		Z3		$15.82
73562	X-ray exam of knee 3		Z3		$19.91
73564	X-ray exam knee 4 or more		Z3		$22.97
73565	X-ray exam of knees		Z3		$18.12
73580	Contrast x-ray of knee joint		N1		
73590	X-ray exam of lower leg		Z3		$14.29
73592	X-ray exam of leg infant		Z3		$17.35
73600	X-ray exam of ankle		Z3		$15.31
73610	X-ray exam of ankle		Z3		$18.12
73615	Contrast x-ray of ankle		N1		
73620	X-ray exam of foot		Z3		$14.80
73630	X-ray exam of foot		Z3		$17.35
73650	X-ray exam of heel		Z3		$15.06
73660	X-ray exam of toe(s)		Z3		$17.10
73700	Ct lower extremity w/o dye		Z2	2.6	$109.04
73701	Ct lower extremity w/dye		Z2	4.0212	$168.65
73702	Ct lwr extremity w/o&w/dye		Z2	4.483	$188.01
73706	Ct angio lwr extr w/o&w/dye		Z2	4.5406	$190.43
73718	Mri lower extremity w/o dye		Z2	4.5995	$192.90
73719	Mri lower extremity w/dye		Z2	5.861	$245.80
73720	Mri lwr extremity w/o&w/dye		Z2	7.1569	$300.15
73721	Mri jnt of lwr extre w/o dye		Z2	4.5995	$192.90
73722	Mri joint of lwr extr w/dye		Z2	5.861	$245.80
73723	Mri joint lwr extr w/o&w/dye		Z2	7.1569	$300.15
74000	X-ray exam of abdomen		Z3		$12.25
74010	X-ray exam of abdomen		Z3		$20.16
74020	X-ray exam of abdomen		Z3		$20.42
74022	X-ray exam series abdomen		Z3		$24.76
74150	Ct abdomen w/o dye		Z2	2.6	$109.04
74160	Ct abdomen w/dye		Z2	4.0212	$168.65
74170	Ct abdomen w/o & w/dye		Z2	4.483	$188.01
74175	Ct angio abdom w/o & w/dye		Z2	4.5406	$190.43
74176	Ct abd & pelvis w/o contrast	NI	Z3		$99.28

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
74177	Ct abdomen&pelvis w/contrast	NI	Z2	4.0212	$168.65
74178	Ct abd&pelv 1+ section/regns	NI	Z2	4.483	$188.01
74181	Mri abdomen w/o dye		Z2	4.5995	$192.90
74182	Mri abdomen w/dye		Z2	5.861	$245.80
74183	Mri abdomen w/o & w/dye		Z2	7.1569	$300.15
74190	X-ray exam of peritoneum		N1		
74210	Contrst x-ray exam of throat		Z3		$45.94
74220	Contrast x-ray esophagus		Z2	1.1632	$48.78
74230	Cine/vid x-ray throat/esoph		Z2	1.1632	$48.78
74235	Remove esophagus obstruction		N1		
74240	X-ray exam upper gi tract		Z2	1.1632	$48.78
74241	X-ray exam upper gi tract		Z2	1.1632	$48.78
74245	X-ray exam upper gi tract		Z2	1.9043	$79.86
74246	Contrst x-ray uppr gi tract		Z2	1.1632	$48.78
74247	Contrst x-ray uppr gi tract		Z2	1.1632	$48.78
74249	Contrst x-ray uppr gi tract		Z2	1.9043	$79.86
74250	X-ray exam of small bowel		Z2	1.1632	$48.78
74251	X-ray exam of small bowel		Z2	1.9043	$79.86
74260	X-ray exam of small bowel		Z2	1.1632	$48.78
74261	Ct colonography dx		Z2	2.6	$109.04
74262	Ct colonography dx w/dye		Z2	4.0212	$168.65
74270	Contrast x-ray exam of colon		Z2	1.1632	$48.78
74280	Contrast x-ray exam of colon		Z2	1.9043	$79.86
74283	Contrast x-ray exam of colon		Z2	1.1632	$48.78
74290	Contrast x-ray gallbladder		Z3		$39.81
74291	Contrast x-rays gallbladder		Z3		$40.83
74300	X-ray bile ducts/pancreas		N1		
74301	X-rays at surgery add-on		N1		
74305	X-ray bile ducts/pancreas		N1		
74320	Contrast x-ray of bile ducts		N1		
74327	X-ray bile stone removal		N1		
74328	X-ray bile duct endoscopy		N1		
74329	X-ray for pancreas endoscopy		N1		
74330	X-ray bile/panc endoscopy		N1		
74340	X-ray guide for GI tube		N1		
74355	X-ray guide intestinal tube		N1		

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
74360	X-ray guide gi dilation		N1		
74363	X-ray bile duct dilation		N1		
74400	Contrst x-ray urinary tract		Z3		$66.36
74410	Contrst x-ray urinary tract		Z3		$68.65
74415	Contrst x-ray urinary tract		Z3		$84.99
74420	Contrst x-ray urinary tract		Z2	2.3622	$99.07
74425	Contrst x-ray urinary tract		N1		
74430	Contrast x-ray bladder		N1		
74440	X-ray male genital tract		N1		
74445	X-ray exam of penis		N1		
74450	X-ray urethra/bladder		N1		
74455	X-ray urethra/bladder		N1		
74470	X-ray exam of kidney lesion		N1		
74475	X-ray control cath insert		N1		
74480	X-ray control cath insert		N1		
74485	X-ray guide gu dilation		N1		
74710	X-ray measurement of pelvis		Z3		$17.35
74740	X-ray female genital tract		N1		
74742	X-ray fallopian tube		N1		
74775	X-ray exam of perineum		Z2	2.3622	$99.07
75557	Cardiac mri for morph		Z2	4.5995	$192.90
75559	Cardiac mri w/stress img		Z2	4.5995	$192.90
75561	Cardiac mri for morph w/dye		Z2	7.1569	$300.15
75563	Card mri w/stress img & dye		Z2	7.1569	$300.15
75565	Card mri veloc flow mapping		N1		
75571	Ct hrt w/o dye w/ca test		Z2	0.6201	$26.01
75572	Ct hrt w/3d image		Z2	3.4451	$144.48
75573	Ct hrt w/3d image congen		Z2	3.4451	$144.48
75574	Ct angio hrt w/3d image		Z2	3.4451	$144.48
75600	Contrast x-ray exam of aorta		N1		
75605	Contrast x-ray exam of aorta		N1		
75625	Contrast x-ray exam of aorta		N1		
75630	X-ray aorta leg arteries		N1		
75635	Ct angio abdominal arteries		N1		
75650	Artery x-rays head & neck		N1		
75658	Artery x-rays arm		N1		

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
75660	Artery x-rays head & neck		N1		
75662	Artery x-rays head & neck		N1		
75665	Artery x-rays head & neck		N1		
75671	Artery x-rays head & neck		N1		
75676	Artery x-rays neck		N1		
75680	Artery x-rays neck		N1		
75685	Artery x-rays spine		N1		
75705	Artery x-rays spine		N1		
75710	Artery x-rays arm/leg		N1		
75716	Artery x-rays arms/legs		N1		
75722	Artery x-rays kidney		N1		
75724	Artery x-rays kidneys		N1		
75726	Artery x-rays abdomen		N1		
75731	Artery x-rays adrenal gland		N1		
75733	Artery x-rays adrenals		N1		
75736	Artery x-rays pelvis		N1		
75741	Artery x-rays lung		N1		
75743	Artery x-rays lungs		N1		
75746	Artery x-rays lung		N1		
75756	Artery x-rays chest		N1		
75774	Artery x-ray each vessel		N1		
75791	Av dialysis shunt imaging		N1		
75801	Lymph vessel x-ray arm/leg		N1		
75803	Lymph vessel x-ray arms/legs		N1		
75805	Lymph vessel x-ray trunk		N1		
75807	Lymph vessel x-ray trunk		N1		
75809	Nonvascular shunt x-ray		N1		
75810	Vein x-ray spleen/liver		N1		
75820	Vein x-ray arm/leg		N1		
75822	Vein x-ray arms/legs		N1		
75825	Vein x-ray trunk		N1		
75827	Vein x-ray chest		N1		
75831	Vein x-ray kidney		N1		
75833	Vein x-ray kidneys		N1		
75840	Vein x-ray adrenal gland		N1		
75842	Vein x-ray adrenal glands		N1		

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
75860	Vein x-ray neck		N1		
75870	Vein x-ray skull		N1		
75872	Vein x-ray skull		N1		
75880	Vein x-ray eye socket		N1		
75885	Vein x-ray liver		N1		
75887	Vein x-ray liver		N1		
75889	Vein x-ray liver		N1		
75891	Vein x-ray liver		N1		
75893	Venous sampling by catheter		N1		
75894	X-rays transcath therapy		N1		
75896	X-rays transcath therapy		N1		
75898	Follow-up angiography		N1		
75901	Remove cva device obstruct		N1		
75902	Remove cva lumen obstruct		N1		
75940	X-ray placement vein filter		N1		
75945	Intravascular us		N1		
75946	Intravascular us add-on		N1		
75960	Transcath iv stent rs&i		N1		
75961	Retrieval broken catheter		N1		
75962	Repair arterial blockage		N1		
75964	Repair artery blockage each		N1		
75966	Repair arterial blockage		N1		
75968	Repair artery blockage each		N1		
75970	Vascular biopsy		N1		
75978	Repair venous blockage		N1		
75980	Contrast xray exam bile duct		N1		
75982	Contrast xray exam bile duct		N1		
75984	Xray control catheter change		N1		
75989	Abscess drainage under x-ray		N1		
75992	Atherectomy, x-ray exam	CH	D5		
75993	Atherectomy, x-ray exam	CH	D5		
75994	Atherectomy, x-ray exam	CH	D5		
75995	Atherectomy, x-ray exam	CH	D5		
75996	Atherectomy, x-ray exam	CH	D5		
76000	Fluoroscope examination		N1		
76001	Fluoroscope exam extensive		N1		

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76010	X-ray nose to rectum		Z3		$14.04
76080	X-ray exam of fistula		N1		
76098	X-ray exam breast specimen		N1		
76100	X-ray exam of body section		Z2	1.0175	$42.67
76101	Complex body section x-ray		Z3		$108.21
76102	Complex body section x-rays		Z2	3.0843	$129.35
76120	Cine/video x-rays		Z3		$43.90
76125	Cine/video x-rays add-on		N1		
76150	X-ray exam, dry process	CH	D5		
76350	Special x-ray contrast study	CH	D5		
76376	3d render w/o postprocess		N1		
76377	3d rendering w/postprocess		N1		
76380	CAT scan follow-up study		Z2	1.5222	$63.84
76496	Fluoroscopic procedure		Z2	1.1199	$46.97
76497	Ct procedure		Z2	1.5222	$63.84
76498	Mri procedure		Z2	4.5995	$192.90
76499	Radiographic procedure		Z2	0.6041	$25.34
76506	Echo exam of head		Z2	0.8349	$35.01
76510	Ophth us b & quant a		Z3		$55.89
76511	Ophth us quant a only		Z3		$36.50
76512	Ophth us b w/non-quant a		Z3		$30.37
76513	Echo exam of eye water bath		Z3		$40.58
76514	Echo exam of eye thickness		Z3		$3.06
76516	Echo exam of eye		Z3		$32.16
76519	Echo exam of eye		Z3		$35.99
76529	Echo exam of eye		Z3		$31.39
76536	Us exam of head and neck		Z2	1.2914	$54.16
76604	Us exam chest		Z2	0.8349	$35.01
76645	Us exam breast(s)		Z2	0.8349	$35.01
76700	Us exam abdom complete		Z2	1.2914	$54.16
76705	Echo exam of abdomen		Z2	1.2914	$54.16
76770	Us exam abdo back wall comp		Z2	1.2914	$54.16
76775	Us exam abdo back wall lim		Z2	1.2914	$54.16
76776	Us exam k transpl w/doppler		Z2	1.2914	$54.16
76800	Us exam spinal canal		Z2	1.2914	$54.16
76801	Ob us < 14 wks single fetus		Z2	1.2914	$54.16

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
76802	Ob us < 14 wks addl fetus		Z3		$21.69
76805	Ob us >/= 14 wks sngl fetus		Z2	1.2914	$54.16
76810	Ob us >/= 14 wks addl fetus		Z3		$37.52
76811	Ob us detailed sngl fetus		Z3		$75.54
76812	Ob us detailed addl fetus		Z2	0.8349	$35.01
76813	Ob us nuchal meas 1 gest		Z2	0.8349	$35.01
76814	Ob us nuchal meas add-on		Z3		$24.50
76815	Ob us limited fetus(s)		Z2	0.8349	$35.01
76816	Ob us follow-up per fetus		Z2	0.8349	$35.01
76817	Transvaginal us obstetric		Z2	0.8349	$35.01
76818	Fetal biophys profile w/nst		Z3		$53.60
76819	Fetal biophys profil w/o nst		Z3		$40.83
76820	Umbilical artery echo		Z3		$16.59
76821	Middle cerebral artery echo		Z2	0.8349	$35.01
76825	Echo exam of fetal heart		Z3		$102.60
76826	Echo exam of fetal heart		Z3		$64.06
76827	Echo exam of fetal heart		Z3		$28.84
76828	Echo exam of fetal heart		Z3		$16.08
76830	Transvaginal us non-ob		Z2	1.2914	$54.16
76831	Echo exam uterus		Z3		$68.14
76856	Us exam pelvic complete		Z2	1.2914	$54.16
76857	Us exam pelvic limited		Z2	0.8349	$35.01
76870	Us exam scrotum		Z2	1.2914	$54.16
76872	Us transrectal		Z2	1.2914	$54.16
76873	Echograp trans r pros study		Z2	1.2914	$54.16
76880	Us exam, extremity	CH	D5		
76881	Us xtr non-vasc complete	NI	Z2	1.2914	$54.16
76882	Us xtr non-vasc lmtd	NI	Z3		$7.40
76885	Us exam infant hips dynamic		Z2	0.8349	$35.01
76886	Us exam infant hips static		Z2	0.8349	$35.01
76930	Echo guide cardiocentesis		N1		
76932	Echo guide for heart biopsy		N1		
76936	Echo guide for artery repair		Z2	1.4282	$59.90
76937	Us guide vascular access		N1		
76940	Us guide tissue ablation		N1		
76941	Echo guide for transfusion		N1		

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76942	Echo guide for biopsy		N1		
76945	Echo guide villus sampling		N1		
76946	Echo guide for amniocentesis		N1		
76948	Echo guide ova aspiration		N1		
76950	Echo guidance radiotherapy		N1		
76965	Echo guidance radiotherapy		N1		
76970	Ultrasound exam follow-up		Z2	0.8349	$35.01
76975	GI endoscopic ultrasound		N1		
76977**	Us bone density measure		Z3		$5.61
76998	Us guide intraop		N1		
76999	Echo examination procedure		Z2	0.8349	$35.01
77001	Fluoroguide for vein device		N1		
77002	Needle localization by xray		N1		
77003	Fluoroguide for spine inject		N1		
77011	Ct scan for localization		N1		
77012	Ct scan for needle biopsy		N1		
77013	Ct guide for tissue ablation		N1		
77014	Ct scan for therapy guide		N1		
77021	Mr guidance for needle place		N1		
77022	Mri for tissue ablation		N1		
77031	Stereotact guide for brst bx		N1		
77032	Guidance for needle breast		N1		
77053	X-ray of mammary duct		N1		
77054	X-ray of mammary ducts		N1		
77071	X-ray stress view		Z3		$22.97
77072	X-rays for bone age		Z3		$10.72
77073	X-rays bone length studies		Z3		$18.12
77074	X-rays bone survey limited		Z3		$35.73
77075	X-rays bone survey complete		Z2	1.0175	$42.67
77076	X-rays bone survey infant		Z2	1.0175	$42.67
77077	Joint survey single view		Z3		$19.40
77078**	Ct bone density axial		Z2	0.9458	$39.67
77079**	Ct bone density peripheral		Z3		$30.12
77080**	Dxa bone density axial		Z2	0.9458	$39.67
77081**	Dxa bone density/peripheral		Z3		$14.04
77082	Dxa bone density vert fx		Z3		$14.04

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
77083**	Radiographic absorptiometry		Z3		$11.48
77084	Magnetic image bone marrow		Z2	4.5995	$192.90
77280	Set radiation therapy field		Z2	1.4013	$58.77
77285	Set radiation therapy field		Z2	3.6429	$152.78
77290	Set radiation therapy field		Z2	3.6429	$152.78
77295	Set radiation therapy field		Z3		$252.66
77299	Radiation therapy planning		Z2	1.4013	$58.77
77300	Radiation therapy dose plan		Z3		$29.09
77301	Radiotherapy dose plan imrt		Z2	12.4299	$521.30
77305	Teletx isodose plan simple		Z3		$23.48
77310	Teletx isodose plan intermed		Z3		$31.14
77315	Teletx isodose plan complex		Z3		$48.75
77321	Special teletx port plan		Z3		$44.92
77326	Brachytx isodose calc simp		Z2	1.4013	$58.77
77327	Brachytx isodose calc interm		Z3		$102.09
77328	Brachytx isodose plan compl		Z3		$129.91
77331	Special radiation dosimetry		Z3		$14.55
77332	Radiation treatment aid(s)		Z3		$38.79
77333	Radiation treatment aid(s)		Z3		$13.27
77334	Radiation treatment aid(s)		Z3		$69.16
77336	Radiation physics consult		Z3		$39.30
77338	Design mlc device for imrt		Z3		$198.05
77370	Radiation physics consult		Z2	1.4013	$58.77
77371	Srs multisource		Z2	102.7552	$4,309.45
77399	External radiation dosimetry		Z2	1.4013	$58.77
77401	Radiation treatment delivery		Z3		$19.14
77402	Radiation treatment delivery		Z2	1.312	$55.02
77403	Radiation treatment delivery		Z2	1.312	$55.02
77404	Radiation treatment delivery		Z2	1.312	$55.02
77406	Radiation treatment delivery		Z2	1.312	$55.02
77407	Radiation treatment delivery		Z2	1.312	$55.02
77408	Radiation treatment delivery		Z2	1.312	$55.02
77409	Radiation treatment delivery		Z2	1.312	$55.02
77411	Radiation treatment delivery		Z2	2.1533	$90.31
77412	Radiation treatment delivery		Z2	2.1533	$90.31
77413	Radiation treatment delivery		Z2	2.1533	$90.31

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
77414	Radiation treatment delivery		Z2	2.1533	$90.31
77416	Radiation treatment delivery		Z2	2.1533	$90.31
77417	Radiology port film(s)		N1		
77418	Radiation tx delivery imrt		Z2	5.8777	$246.50
77421	Stereoscopic x-ray guidance		N1		
77422	Neutron beam tx simple		Z2	2.1533	$90.31
77423	Neutron beam tx complex		Z2	2.1533	$90.31
77435	Sbrt management		N1		
77470	Special radiation treatment		Z3		$73.25
77520	Proton trmt simple w/o comp		Z2	13.8378	$580.34
77522	Proton trmt simple w/comp		Z2	13.8378	$580.34
77523	Proton trmt intermediate		Z2	18.1017	$759.17
77525	Proton treatment complex		Z2	18.1017	$759.17
77600	Hyperthermia treatment		Z2	5.2119	$218.58
77605	Hyperthermia treatment		Z2	5.2119	$218.58
77610	Hyperthermia treatment		Z2	5.2119	$218.58
77615	Hyperthermia treatment		Z2	5.2119	$218.58
77620	Hyperthermia treatment		Z2	5.2119	$218.58
77750	Infuse radioactive materials		Z3		$76.05
77761	Apply intrcav radiat simple		Z3		$132.20
77762	Apply intrcav radiat interm		Z3		$154.66
77763	Apply intrcav radiat compl		Z2	4.7608	$199.66
77776	Apply interstit radiat simpl		Z3		$138.07
77777	Apply interstit radiat inter		Z3		$150.83
77778	Apply interstit radiat compl		Z3		$205.19
77785	Hdr brachytx 1 channel		Z3		$111.79
77786	Hdr brachytx 2-12 channel		Z3		$308.56
77787	Hdr brachytx over 12 chan		Z2	9.3901	$393.81
77789	Apply surface radiation		Z3		$40.58
77790	Radiation handling		N1		
77799	Radium/radioisotope therapy		Z2	4.7608	$199.66
78000	Thyroid single uptake		Z2	1.3515	$56.68
78001	Thyroid multiple uptakes		Z2	1.3515	$56.68
78003	Thyroid suppress/stimul		Z2	1.3515	$56.68
78006	Thyroid imaging with uptake		Z2	2.944	$123.47
78007	Thyroid image mult uptakes		Z2	2.944	$123.47

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78010	Thyroid imaging		Z2	1.7811	$74.70
78011	Thyroid imaging with flow		Z2	1.7811	$74.70
78015	Thyroid met imaging		Z2	3.8911	$163.19
78016	Thyroid met imaging/studies		Z2	3.8911	$163.19
78018	Thyroid met imaging body		Z2	3.8911	$163.19
78020	Thyroid met uptake		N1		
78070	Parathyroid nuclear imaging		Z2	2.944	$123.47
78075	Adrenal nuclear imaging		Z2	11.0689	$464.22
78099	Endocrine nuclear procedure		Z2	1.7811	$74.70
78102	Bone marrow imaging ltd		Z2	3.4473	$144.58
78103	Bone marrow imaging mult		Z2	3.4473	$144.58
78104	Bone marrow imaging body		Z2	3.4473	$144.58
78110	Plasma volume single		Z2	5.6116	$235.34
78111	Plasma volume multiple		Z2	5.6116	$235.34
78120	Red cell mass single		Z2	5.6116	$235.34
78121	Red cell mass multiple		Z2	5.6116	$235.34
78122	Blood volume		Z2	5.6116	$235.34
78130	Red cell survival study		Z2	5.6116	$235.34
78135	Red cell survival kinetics		Z2	5.6116	$235.34
78140	Red cell sequestration		Z2	5.6116	$235.34
78185	Spleen imaging		Z2	3.4473	$144.58
78190	Platelet survival kinetics		Z2	2.3324	$97.82
78191	Platelet survival		Z2	2.3324	$97.82
78195	Lymph system imaging		Z2	3.4473	$144.58
78199	Blood/lymph nuclear exam		Z2	3.4473	$144.58
78201	Liver imaging		Z2	3.5561	$149.14
78202	Liver imaging with flow		Z2	3.5561	$149.14
78205	Liver imaging (3D)		Z2	3.5561	$149.14
78206	Liver image (3d) with flow		Z2	3.5561	$149.14
78215	Liver and spleen imaging		Z2	3.5561	$149.14
78216	Liver & spleen image/flow		Z2	3.5561	$149.14
78220	Liver function study		Z2	3.5561	$149.14
78223	Hepatobiliary imaging		Z2	3.5561	$149.14
78230	Salivary gland imaging		Z2	3.2096	$134.61
78231	Serial salivary imaging		Z2	3.2096	$134.61
78232	Salivary gland function exam		Z2	3.2096	$134.61

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78258	Esophageal motility study		Z2	3.2096	$134.61
78261	Gastric mucosa imaging		Z2	3.2096	$134.61
78262	Gastroesophageal reflux exam		Z2	3.2096	$134.61
78264	Gastric emptying study		Z2	3.2096	$134.61
78270	Vit B-12 absorption exam		Z2	2.3324	$97.82
78271	Vit b-12 absrp exam int fac		Z2	2.3324	$97.82
78272	Vit b-12 absorp combined		Z2	2.3324	$97.82
78278	Acute GI blood loss imaging		Z2	3.2096	$134.61
78282	GI protein loss exam		Z2	3.2096	$134.61
78290	Meckels divert exam		Z2	3.2096	$134.61
78291	Leveen/shunt patency exam		Z2	3.2096	$134.61
78299	GI nuclear procedure		Z2	3.2096	$134.61
78300	Bone imaging limited area		Z2	3.282	$137.64
78305	Bone imaging multiple areas		Z2	3.282	$137.64
78306	Bone imaging whole body		Z2	3.282	$137.64
78315	Bone imaging 3 phase		Z2	3.282	$137.64
78320	Bone imaging (3D)		Z2	3.282	$137.64
78399	Musculoskeletal nuclear exam		Z2	3.282	$137.64
78414	Non-imaging heart function		Z2	3.9082	$163.91
78428	Cardiac shunt imaging		Z2	3.9082	$163.91
78445	Vascular flow imaging		Z2	2.6872	$112.70
78451	Ht muscle image spect sing		Z2	10.1921	$427.45
78452	Ht muscle image spect mult		Z2	10.1921	$427.45
78453	Ht muscle image planar sing		Z2	10.1921	$427.45
78454	Ht musc image planar mult		Z2	10.1921	$427.45
78456	Acute venous thrombus image		Z2	2.6872	$112.70
78457	Venous thrombosis imaging		Z2	2.6872	$112.70
78458	Ven thrombosis images bilat		Z2	2.6872	$112.70
78459	Heart muscle imaging (PET)		Z2	14.8525	$622.90
78466	Heart infarct image		Z2	3.9082	$163.91
78468	Heart infarct image (ef)		Z2	3.9082	$163.91
78469	Heart infarct image (3D)		Z2	3.9082	$163.91
78472	Gated heart planar single		Z2	3.9082	$163.91
78473	Gated heart multiple		Z2	3.9082	$163.91
78481	Heart first pass single		Z2	3.9082	$163.91
78483	Heart first pass multiple		Z2	3.9082	$163.91

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78491	Heart image (pet) single		Z2	14.8525	$622.90
78492	Heart image (pet) multiple		Z2	14.8525	$622.90
78494	Heart image spect		Z2	3.9082	$163.91
78496	Heart first pass add-on		N1		
78499	Cardiovascular nuclear exam		Z2	3.9082	$163.91
78580	Lung perfusion imaging		Z2	2.64	$110.72
78584	Lung V/Q image single breath		Z2	4.291	$179.96
78585	Lung V/Q imaging		Z2	4.291	$179.96
78586	Aerosol lung image single		Z2	2.64	$110.72
78587	Aerosol lung image multiple		Z2	2.64	$110.72
78588	Perfusion lung image		Z2	4.291	$179.96
78591	Vent image 1 breath 1 proj		Z2	2.64	$110.72
78593	Vent image 1 proj gas		Z2	2.64	$110.72
78594	Vent image mult proj gas		Z2	2.64	$110.72
78596	Lung differential function		Z2	4.291	$179.96
78599	Respiratory nuclear exam		Z2	2.64	$110.72
78600	Brain image < 4 views		Z2	3.2221	$135.13
78601	Brain image w/flow < 4 views		Z2	7.9974	$335.40
78605	Brain image 4+ views		Z2	3.2221	$135.13
78606	Brain image w/flow 4 + views		Z2	7.9974	$335.40
78607	Brain imaging (3D)		Z2	7.9974	$335.40
78608	Brain imaging (PET)		Z2	13.9757	$586.13
78610	Brain flow imaging only		Z2	3.2221	$135.13
78630	Cerebrospinal fluid scan		Z2	7.9974	$335.40
78635	CSF ventriculography		Z2	7.9974	$335.40
78645	CSF shunt evaluation		Z2	3.2221	$135.13
78647	Cerebrospinal fluid scan		Z2	7.9974	$335.40
78650	CSF leakage imaging		Z2	7.9974	$335.40
78660	Nuclear exam of tear flow		Z2	3.2221	$135.13
78699	Nervous system nuclear exam		Z2	3.2221	$135.13
78700	Kidney imaging morphol		Z2	4.3116	$180.82
78701	Kidney imaging with flow		Z2	4.3116	$180.82
78707	K flow/funct image w/o drug		Z2	4.3116	$180.82
78708	K flow/funct image w/drug		Z2	4.3116	$180.82
78709	K flow/funct image multiple		Z2	4.3116	$180.82
78710	Kidney imaging (3D)		Z2	4.3116	$180.82

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78725	Kidney function study		Z2	2.3324	$97.82
78730	Urinary bladder retention		Z2	1.3515	$56.68
78740	Ureteral reflux study		Z2	4.3116	$180.82
78761	Testicular imaging w/flow		Z2	4.3116	$180.82
78799	Genitourinary nuclear exam		Z2	4.3116	$180.82
78800	Tumor imaging limited area		Z2	3.8911	$163.19
78801	Tumor imaging mult areas		Z2	6.3706	$267.18
78802	Tumor imaging whole body		Z2	6.3706	$267.18
78803	Tumor imaging (3D)		Z2	6.3706	$267.18
78804	Tumor imaging whole body		Z2	11.0689	$464.22
78805	Abscess imaging ltd area		Z2	6.3706	$267.18
78806	Abscess imaging whole body		Z2	6.3706	$267.18
78807	Nuclear localization/abscess		Z2	6.3706	$267.18
78808	Iv inj ra drug dx study		N1		
78811	Pet image ltd area		Z2	13.9757	$586.13
78812	Pet image skull-thigh		Z2	13.9757	$586.13
78813	Pet image full body		Z2	13.9757	$586.13
78814	Pet image w/ct lmtd		Z2	13.9757	$586.13
78815	Pet image w/ct skull-thigh		Z2	13.9757	$586.13
78816	Pet image w/ct full body		Z2	13.9757	$586.13
78999	Nuclear diagnostic exam		Z2	1.3515	$56.68
79005	Nuclear rx oral admin		Z3		$41.35
79101	Nuclear rx iv admin		Z3		$44.66
79200	Nuclear rx intracav admin		Z3		$51.04
79300	Nuclr rx interstit colloid		Z2	3.006	$126.07
79403	Hematopoietic nuclear tx		Z3		$68.91
79440	Nuclear rx intra-articular		Z3		$42.62
79445	Nuclear rx intra-arterial		Z2	3.006	$126.07
79999	Nuclear medicine therapy		Z2	3.006	$126.07
90371	Hep b ig im		K2		$114.18
90375	Rabies ig im/sc		K2		$165.12
90376	Rabies ig heat treated		K2		$159.71
90378	Rsv mab im 50mg		K2		$74.65
90385	Rh ig minidose im		N1		
90396	Varicella-zoster ig im		K2		$129.48
90476	Adenovirus vaccine type 4		K2		$23.24

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90585	Bcg vaccine percut		K2		$110.93
90632	Hep a vaccine adult im		N1		
90633	Hep a vacc ped/adol 2 dose		N1		
90634	Hep a vacc ped/adol 3 dose		N1		
90636	Hep a/hep b vacc adult im		N1		
90645	Hib vaccine hboc im		N1		
90646	Hib vaccine prp-d im		N1		
90647	Hib vaccine prp-omp im		N1		
90648	Hib vaccine prp-t im		N1		
90655**	Flu vaccine no preserv 6-35m		L1		
90656**	Flu vaccine no preserv 3 & >		L1		
90657**	Flu vaccine 3 yrs im		L1		
90660**	Flu vaccine nasal		L1		
90662**	Flu vacc prsv free inc antig		L1		
90665	Lyme disease vaccine im	CH	N1		
90669**	Pneumococcal vacc 7 val im		L1		
90670**	Pneumococcal vacc 13 val im		L1		
90675	Rabies vaccine im		K2		$200.66
90676	Rabies vaccine id		K2		$107.83
90680	Rotovirus vacc 3 dose oral		K2		$73.07
90681	Rotavirus vacc 2 dose oral		K2		$101.53
90690	Typhoid vaccine oral		N1		
90691	Typhoid vaccine im		N1		
90692	Typhoid vaccine h-p sc/id		N1		
90696	Dtap-ipv vacc 4-6 yr im		N1		
90698	Dtap-hib-ip vaccine im		N1		
90700	Dtap vaccine < 7 yrs im		N1		
90701	Dtp vaccine im		N1		
90702	Dt vaccine < 7 im		N1		
90703	Tetanus vaccine im		N1		
90704	Mumps vaccine sc		N1		
90705	Measles vaccine sc		N1		
90706	Rubella vaccine sc		N1		
90707	Mmr vaccine sc		N1		
90708	Measles-rubella vaccine sc		N1		
90710	Mmrv vaccine sc		N1		

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90712	Oral poliovirus vaccine		N1		
90713	Poliovirus ipv sc/im		N1		
90714	Td vaccine no prsrv >/= 7 im		N1		
90715	Tdap vaccine >7 im		N1		
90717	Yellow fever vaccine sc		N1		
90718	Td vaccine > 7 im		N1		
90719	Diphtheria vaccine im		N1		
90720	Dtp/hib vaccine im		N1		
90721	Dtap/hib vaccine im		N1		
90732**	Pneumococcal vaccine		L1		
90733	Meningococcal vaccine sc		K2		$102.44
90734	Meningococcal vaccine im		K2		$95.06
90735	Encephalitis vaccine sc		K2		$101.12
90740**	Hepb vacc ill pat 3 dose im		F4		
90743**	Hep b vacc adol 2 dose im		F4		
90744**	Hepb vacc ped/adol 3 dose im		F4		
90746**	Hep b vaccine adult im		F4		
90747**	Hepb vacc ill pat 4 dose im		F4		
90749	Vaccine toxoid		N1		
A4218	Sterile saline or water		N1		
A4220	Infusion pump refill kit		N1		
A4248	Chlorhexidine antisept		N1		
A4262	Temporary tear duct plug		N1		
A4263	Permanent tear duct plug		N1		
A4270	Disposable endoscope sheath		N1		
A4300	Cath impl vasc access portal		N1		
A4301	Implantable access syst perc		N1		
A4305	Drug delivery system >=50 ML		N1		
A4306	Drug delivery system <=50 ml		N1		
A4641	Radiopharm dx agent noc		N1		
A4642	In111 satumomab		N1		
A4648	Implantable tissue marker		N1		
A4650	Implant radiation dosimeter		N1		
A9500	Tc99m sestamibi		N1		
A9501	Technetium TC-99m teboroxime		N1		
A9502	Tc99m tetrofosmin		N1		

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A9503	Tc99m medronate		N1		
A9504	Tc99m apcitide		N1		
A9505	TL201 thallium		N1		
A9507	In111 capromab		N1		
A9508	I131 iodobenguate, dx		N1		
A9509	Iodine I-123 sod iodide mil		N1		
A9510	Tc99m disofenin		N1		
A9512	Tc99m pertechnetate		N1		
A9516	Iodine I-123 sod iodide mic		N1		
A9521	Tc99m exametazime		N1		
A9524	I131 serum albumin, dx		N1		
A9526	Nitrogen N-13 ammonia		N1		
A9527	Iodine I-125 sodium iodide		H2		$21.65
A9528	Iodine I-131 iodide cap, dx		N1		
A9529	I131 iodide sol, dx		N1		
A9531	I131 max 100uCi		N1		
A9532	I125 serum albumin, dx		N1		
A9536	Tc99m depreotide		N1		
A9537	Tc99m mebrofenin		N1		
A9538	Tc99m pyrophosphate		N1		
A9539	Tc99m pentetate		N1		
A9540	Tc99m MAA		N1		
A9541	Tc99m sulfur colloid		N1		
A9542	In111 ibritumomab, dx		N1		
A9544	I131 tositumomab, dx		N1		
A9546	Co57/58		N1		
A9547	In111 oxyquinoline		N1		
A9548	In111 pentetate		N1		
A9550	Tc99m gluceptate		N1		
A9551	Tc99m succimer		N1		
A9552	F18 fdg		N1		
A9553	Cr51 chromate		N1		
A9554	I125 iothalamate, dx		N1		
A9555	Rb82 rubidium		N1		
A9556	Ga67 gallium		N1		
A9557	Tc99m bicisate		N1		

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A9558	Xe133 xenon 10mci		N1		
A9559	Co57 cyano		N1		
A9560	Tc99m labeled rbc		N1		
A9561	Tc99m oxidronate		N1		
A9562	Tc99m mertiatide		N1		
A9566	Tc99m fanolesomab		N1		
A9567	Technetium TC-99m aerosol		N1		
A9568	Technetium tc99m arcitumomab		N1		
A9569	Technetium TC-99m auto WBC		N1		
A9570	Indium In-111 auto WBC		N1		
A9571	Indium IN-111 auto platelet		N1		
A9572	Indium In-111 pentetreotide		N1		
A9576	Inj prohance multipack		N1		
A9577	Inj multihance		N1		
A9578	Inj multihance multipack		N1		
A9579	Gad-base MR contrast NOS,1ml		N1		
A9580	Sodium fluoride F-18		N1		
A9581	Gadoxetate disodium inj	CH	N1		
A9582	Iodine I-123 iobenguane		K2		$2,394.59
A9583	Gadofosveset trisodium inj		K2		$12.82
A9698	Non-rad contrast materialNOC		N1		
C1713	Anchor/screw bn/bn,tis/bn		N1		
C1714	Cath, trans atherectomy, dir		N1		
C1715	Brachytherapy needle		N1		
C1716	Brachytx, non-str, Gold-198		H2		$190.12
C1717	Brachytx, non-str,HDR Ir-192		H2		$218.87
C1719	Brachytx, NS, Non-HDRIr-192		H2		$28.07
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		

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C1731	Cath, EP, 20 or more elec		N1		
C1732	Cath, EP, diag/abl, 3D/vect		N1		
C1733	Cath, EP, othr than cool-tip		N1		
C1749	Endo, colon, retro imaging		J7		
C1750	Cath, hemodialysis,long-term		N1		
C1751	Cath, inf, per/cent/midline		N1		
C1752	Cath,hemodialysis,short-term		N1		
C1753	Cath, intravas ultrasound		N1		
C1754	Catheter, intradiscal		N1		
C1755	Catheter, intraspinal		N1		
C1756	Cath, pacing, transesoph		N1		
C1757	Cath, thrombectomy/embolect		N1		
C1758	Catheter, ureteral		N1		
C1759	Cath, intra echocardiography		N1		
C1760	Closure dev, vasc		N1		
C1762	Conn tiss, human(inc fascia)		N1		
C1763	Conn tiss, non-human		N1		
C1764	Event recorder, cardiac		N1		
C1765	Adhesion barrier		N1		
C1766	Intro/sheath,strble,non-peel		N1		
C1767	Generator, neuro non-recharg		N1		
C1768	Graft, vascular		N1		
C1769	Guide wire		N1		
C1770	Imaging coil, MR, insertable		N1		
C1771	Rep dev, urinary, w/sling		N1		
C1772	Infusion pump, programmable		N1		
C1773	Ret dev, insertable		N1		
C1776	Joint device (implantable)		N1		
C1777	Lead, AICD, endo single coil		N1		
C1778	Lead, neurostimulator		N1		
C1779	Lead, pmkr, transvenous VDD		N1		
C1780	Lens, intraocular (new tech)		N1		
C1781	Mesh (implantable)		N1		
C1782	Morcellator		N1		
C1783	Ocular imp, aqueous drain de		N1		
C1784	Ocular dev, intraop, det ret		N1		

ADDENDUM BB.—FINAL ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
C1785	Pmkr, dual, rate-resp		N1		
C1786	Pmkr, single, rate-resp		N1		
C1787	Patient progr, neurostim		N1		
C1788	Port, indwelling, imp		N1		
C1789	Prosthesis, breast, imp		N1		
C1813	Prosthesis, penile, inflatab		N1		
C1814	Retinal tamp, silicone oil		N1		
C1815	Pros, urinary sph, imp		N1		
C1816	Receiver/transmitter, neuro		N1		
C1817	Septal defect imp sys		N1		
C1818	Integrated keratoprosthesis		N1		
C1819	Tissue localization-excision		N1		
C1820	Generator neuro rechg bat sy		N1		
C1821	Interspinous implant		N1		
C1874	Stent, coated/cov w/del sys		N1		
C1875	Stent, coated/cov w/o del sy		N1		
C1876	Stent, non-coa/non-cov w/del		N1		
C1877	Stent, non-coat/cov w/o del		N1		
C1878	Matrl for vocal cord		N1		
C1879	Tissue marker, implantable		N1		
C1880	Vena cava filter		N1		
C1881	Dialysis access system		N1		
C1882	AICD, other than sing/dual		N1		
C1883	Adapt/ext, pacing/neuro lead		N1		
C1884	Embolization Protect syst		N1		
C1885	Cath, translumin angio laser		N1		
C1887	Catheter, guiding		N1		
C1888	Endovas non-cardiac abl cath		N1		
C1891	Infusion pump,non-prog, perm		N1		
C1892	Intro/sheath,fixed,peel-away		N1		
C1893	Intro/sheath, fixed,non-peel		N1		
C1894	Intro/sheath, non-laser		N1		
C1895	Lead, AICD, endo dual coil		N1		
C1896	Lead, AICD, non sing/dual		N1		
C1897	Lead, neurostim test kit		N1		
C1898	Lead, pmkr, other than trans		N1		

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
C1899	Lead, pmkr/AICD combination		N1		
C1900	Lead, coronary venous		N1		
C2614	Probe, perc lumb disc		N1		
C2615	Sealant, pulmonary, liquid		N1		
C2616	Brachytx, non-str,Yttrium-90		H2		$16,568.83
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		
C2634	Brachytx, non-str, HA, I-125		H2		$56.24
C2635	Brachytx, non-str, HA, P-103		H2		$28.65
C2636	Brachy linear, non-str,P-103		H2		$37.15
C2638	Brachytx, stranded, I-125		H2		$41.62
C2639	Brachytx, non-stranded,I-125		H2		$36.55
C2640	Brachytx, stranded, P-103		H2		$72.73
C2641	Brachytx, non-stranded,P-103		H2		$65.56
C2642	Brachytx, stranded, C-131		H2		$124.28
C2643	Brachytx, non-stranded,C-131		H2		$66.57
C2698	Brachytx, stranded, NOS		H2		$41.62
C2699	Brachytx, non-stranded, NOS		H2		$28.07
C8900	MRA w/cont, abd		Z2	5.861	$245.80
C8901	MRA w/o cont, abd		Z2	4.5995	$192.90
C8902	MRA w/o fol w/cont, abd		Z2	7.1569	$300.15
C8903	MRI w/cont, breast, uni		Z2	5.861	$245.80
C8904	MRI w/o cont, breast, uni		Z2	4.5995	$192.90
C8905	MRI w/o fol w/cont, brst, un		Z2	7.1569	$300.15
C8906	MRI w/cont, breast, bi		Z2	5.861	$245.80

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C8907	MRI w/o cont, breast, bi		Z2	4.5995	$192.90
C8908	MRI w/o fol w/cont, breast,		Z2	7.1569	$300.15
C8909	MRA w/cont, chest		Z2	5.861	$245.80
C8910	MRA w/o cont, chest		Z2	4.5995	$192.90
C8911	MRA w/o fol w/cont, chest		Z2	7.1569	$300.15
C8912	MRA w/cont, lwr ext		Z2	5.861	$245.80
C8913	MRA w/o cont, lwr ext		Z2	4.5995	$192.90
C8914	MRA w/o fol w/cont, lwr ext		Z2	7.1569	$300.15
C8918	MRA w/cont, pelvis		Z2	5.861	$245.80
C8919	MRA w/o cont, pelvis		Z2	4.5995	$192.90
C8920	MRA w/o fol w/cont, pelvis		Z2	7.1569	$300.15
C8931	MRA, w/dye, spinal canal		Z2	5.861	$245.80
C8932	MRA, w/o dye, spinal canal		Z2	4.5995	$192.90
C8933	MRA, w/o&w/dye, spinal canal		Z2	7.1569	$300.15
C8934	MRA, w/dye, upper extremity		Z2	5.861	$245.80
C8935	MRA, w/o dye, upper extr		Z2	4.5995	$192.90
C8936	MRA, w/o&w/dye, upper extr		Z2	7.1569	$300.15
C9113	Inj pantoprazole sodium, via		N1		
C9121	Injection, argatroban		K2		$19.03
C9248	Inj, clevidipine butyrate		K2		$2.97
C9250	Artiss fibrin sealant		K2		$122.05
C9254	Injection, lacosamide		K2		$0.16
C9255	Paliperidone palmitate inj	CH	D5		
C9256	Dexamethasone intravitreal	CH	D5		
C9257	Bevacizumab injection		K2		$1.45
C9258	Telavancin injection	CH	D5		
C9259	Pralatrexate injection	CH	D5		
C9260	Ofatumumab injection	CH	D5		
C9261	Ustekinumab injection	CH	D5		
C9263	Ecallantide injection	CH	D5		
C9264	Tocilizumab injection	CH	D5		
C9265	Romidepsin injection	CH	D5		
C9266	Collagenase clostridium histo	CH	D5		
C9267	Injection, Wilate	CH	D5		
C9268	Capsaicin patch	CH	D5		
C9269	C-1 esterase, berinert	CH	D5		

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C9270	Gammaplex IVIG		K2		$60.42
C9271	Velaglucerase alfa	CH	D5		
C9272	Inj, denosumab		K2		$14.58
C9273	Sipuleucel-T, per infusion		K2		$32,860.00
C9274	Crotalidae Poly Immune Fab	NI	K2		$1,947.49
C9275	Hexaminolevulinate HCl	NI	K2		$636.00
C9276	Cabazitaxel injection	NI	K2		$141.33
C9277	Lumizyme, 1 mg	NI	K2		$14.84
C9278	Incobotulinumtoxin A	NI	K2		$5.57
C9279	Injection, ibuprofen	NI	K2		$1.40
C9352	Neuragen nerve guide, per cm		N1		
C9353	Neurawrap nerve protector,cm		N1		
C9354	Veritas collagen matrix, cm2		N1		
C9355	Neuromatrix nerve cuff, cm		N1		
C9356	TenoGlide tendon prot, cm2	CH	N1		
C9358	SurgiMend, fetal		K2		$10.60
C9359	Implnt,bon void filler-putty	CH	N1		
C9360	SurgiMend, neonatal		K2		$11.26
C9361	NeuroMend nerve wrap		K2		$251.08
C9362	Implnt,bon void filler-strip		K2		$50.09
C9363	Integra Meshed Bil Wound Mat		K2		$19.56
C9364	Porcine implant, Permacol		K2		$18.85
C9367	Endoform Dermal Template		K2		$4.35
C9399	Unclassified drugs or biolog		K7		
E0616	Cardiac event recorder		N1		
E0749	Elec osteogen stim implanted		N1		
E0782	Non-programble infusion pump		N1		
E0783	Programmable infusion pump		N1		
E0785	Replacement impl pump cathet		N1		
E0786	Implantable pump replacement		N1		
G0130**	Single energy x-ray study		Z3		$16.59
G0173	Linear acc stereo radsur com		Z2	45.7191	$1,917.41
G0251	Linear acc based stero radio		Z2	13.1056	$549.64
G0288	Recon, CTA for surg plan		N1		
G0339	Robot lin-radsurg com, first		Z2	45.7191	$1,917.41
G0340	Robt lin-radsurg fractx 2-5		Z2	33.5939	$1,408.89

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J0120	Tetracyclin injection		N1		
J0128	Abarelix injection	CH	D5		
J0129	Abatacept injection		K2		$19.99
J0130	Abciximab injection		K2		$486.03
J0132	Acetylcysteine injection		K2		$2.69
J0133	Acyclovir injection		N1		
J0135	Adalimumab injection		K2		$384.61
J0150	Injection adenosine 6 MG	CH	N1		
J0152	Adenosine injection		K2		$84.21
J0170	Adrenalin epinephrin inject	CH	D5		
J0171	Adrenalin epinephrine inject	NI	N1		
J0180	Agalsidase beta injection		K2		$134.90
J0200	Alatrofloxacin mesylate		N1		
J0205	Alglucerase injection		K2		$41.58
J0207	Amifostine		K2		$315.66
J0210	Methyldopate hcl injection		K2		$39.84
J0215	Alefacept		K2		$33.05
J0220	Alglucosidase alfa injection		K2		$133.92
J0256	Alpha 1 proteinase inhibitor		K2		$3.72
J0278	Amikacin sulfate injection		N1		
J0280	Aminophyllin 250 MG inj		N1		
J0282	Amiodarone HCl		N1		
J0285	Amphotericin B		N1		
J0287	Amphotericin b lipid complex		K2		$9.73
J0288	Ampho b cholesteryl sulfate		K2		$11.89
J0289	Amphotericin b liposome inj		K2		$15.53
J0290	Ampicillin 500 MG inj		N1		
J0295	Ampicillin sodium per 1.5 gm		N1		
J0300	Amobarbital 125 MG inj		N1		
J0330	Succinycholine chloride inj		N1		
J0348	Anidulafungin injection	CH	K2		$1.13
J0360	Hydralazine hcl injection		N1		
J0364	Apomorphine hydrochloride		N1		
J0365	Aprotonin, 10,000 kiu	CH	N1		
J0380	Inj metaraminol bitartrate		N1		
J0390	Chloroquine injection		N1		

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J0400	Aripiprazole injection		N1		
J0456	Azithromycin		N1		
J0461	Atropine sulfate injection		N1		
J0470	Dimecaprol injection	CH	N1		
J0475	Baclofen 10 MG injection		K2		$202.00
J0476	Baclofen intrathecal trial		K2		$72.46
J0480	Basiliximab		K2		$2,017.51
J0500	Dicyclomine injection		N1		
J0515	Inj benztropine mesylate	CH	K2		$58.24
J0520	Bethanechol chloride inject		N1		
J0558	PenG benzathine/procaine inj	NI	N1		
J0559	PenG benzathine/procaine inj	CH	D5		
J0560	Penicillin g benzathine inj	CH	D5		
J0561	Penicillin g benzathine inj	NI	N1		
J0570	Penicillin g benzathine inj	CH	D5		
J0580	Penicillin g benzathine inj	CH	D5		
J0583	Bivalirudin		K2		$2.52
J0585	Injection,onabotulinumtoxinA		K2		$5.44
J0586	AbobotulinumtoxinA		K2		$7.62
J0587	Inj, rimabotulinumtoxinB		K2		$10.48
J0592	Buprenorphine hydrochloride		N1		
J0594	Busulfan injection		K2		$16.45
J0595	Butorphanol tartrate 1 mg		N1		
J0597	C-1 esterase, berinert	NI	K2		$27.53
J0598	C-1 esterase, cinryze		K2		$42.75
J0600	Edetate calcium disodium inj		K2		$194.86
J0610	Calcium gluconate injection		N1		
J0620	Calcium glycer & lact/10 ML		N1		
J0630	Calcitonin salmon injection		K2		$51.46
J0636	Inj calcitriol per 0.1 mcg		N1		
J0637	Caspofungin acetate		K2		$11.99
J0638	Canakinumab injection	NI	K2		$88.62
J0640	Leucovorin calcium injection		N1		
J0641	Levoleucovorin injection		K2		$1.14
J0670	Inj mepivacaine HCL/10 ml		N1		
J0690	Cefazolin sodium injection		N1		

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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	CH	D5		
J0706	Caffeine citrate injection		N1		
J0710	Cephapirin sodium injection		N1		
J0713	Inj ceftazidime per 500 mg		N1		
J0715	Ceftizoxime sodium / 500 MG		N1		
J0718	Certolizumab pegol inj		K2		$3.96
J0720	Chloramphenicol sodium injec		N1		
J0725	Chorionic gonadotropin/1000u		N1		
J0735	Clonidine hydrochloride		K2		$24.52
J0740	Cidofovir injection		K2		$754.01
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		
J0775	Collagenase, clost hist inj	NI	K2		$37.51
J0780	Prochlorperazine injection		N1		
J0795	Corticorelin ovine triflutal		K2		$4.77
J0800	Corticotropin injection		K2		$2,418.30
J0833	Cosyntropin injection NOS		K2		$69.81
J0834	Cosyntropin cortrosyn inj		K2		$82.31
J0850	Cytomegalovirus imm IV /vial		K2		$870.53
J0878	Daptomycin injection		K2		$0.45
J0881	Darbepoetin alfa, non-esrd		K2		$2.87
J0885	Epoetin alfa, non-esrd		K2		$9.59
J0894	Decitabine injection		K2		$30.45
J0895	Deferoxamine mesylate inj		N1		
J0900	Testosterone enanthate inj		N1		
J0945	Brompheniramine maleate inj		K2		$7.50
J0970	Estradiol valerate injection	CH	D5		

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
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		$500.91
J1165	Phenytoin sodium injection		N1		
J1170	Hydromorphone injection		N1		
J1180	Dyphylline injection		N1		
J1190	Dexrazoxane HCl injection		K2		$207.22
J1200	Diphenhydramine hcl injectio		N1		
J1205	Chlorothiazide sodium inj		K2		$432.82
J1212	Dimethyl sulfoxide 50% 50 ML		K2		$70.46
J1230	Methadone injection		N1		
J1240	Dimenhydrinate injection		N1		
J1245	Dipyridamole injection		N1		
J1250	Inj dobutamine HCL/250 mg		N1		
J1260	Dolasetron mesylate		N1		
J1265	Dopamine injection		N1		
J1267	Doripenem injection	CH	N1		
J1270	Injection, doxercalciferol		N1		
J1290	Ecallantide injection	NI	K2		$275.28
J1300	Eculizumab injection		K2		$183.75
J1320	Amitriptyline injection		N1		
J1324	Enfuvirtide injection	CH	N1		
J1325	Epoprostenol injection		N1		
J1327	Eptifibatide injection		K2		$19.91
J1330	Ergonovine maleate injection		N1		

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J1335	Ertapenem injection		N1		
J1364	Erythro lactobionate /500 MG		N1		
J1380	Estradiol valerate 10 MG inj		N1		
J1390	Estradiol valerate 20 MG inj	CH	D5		
J1410	Inj estrogen conjugate 25 MG		K2		$92.21
J1430	Ethanolamine oleate 100 mg		K2		$148.55
J1436	Etidronate disodium inj	CH	N1		
J1438	Etanercept injection		K2		$198.44
J1440	Filgrastim 300 mcg injection		K2		$231.22
J1441	Filgrastim 480 mcg injection		K2		$363.35
J1450	Fluconazole		N1		
J1451	Fomepizole, 15 mg		K2		$7.49
J1453	Fosaprepitant injection		K2		$1.67
J1455	Foscarnet sodium injection		N1		
J1457	Gallium nitrate injection		K2		$2.01
J1458	Galsulfase injection		K2		$333.68
J1459	Inj IVIG privigen 500 mg		K2		$34.76
J1460	Gamma globulin 1 CC inj		K2		$18.71
J1470	Gamma globulin 2 CC inj	CH	D5		
J1480	Gamma globulin 3 CC inj	CH	D5		
J1490	Gamma globulin 4 CC inj	CH	D5		
J1500	Gamma globulin 5 CC inj	CH	D5		
J1510	Gamma globulin 6 CC inj	CH	D5		
J1520	Gamma globulin 7 CC inj	CH	D5		
J1530	Gamma globulin 8 CC inj	CH	D5		
J1540	Gamma globulin 9 CC inj	CH	D5		
J1550	Gamma globulin 10 CC inj	CH	D5		
J1559	Hizentra injection	NI	K2		$13.23
J1560	Gamma globulin > 10 CC inj		K2		$187.06
J1561	Gamunex injection		K2		$37.29
J1562	Vivaglobin, inj		K2		$7.10
J1566	Immune globulin, powder		K2		$29.12
J1568	Octagam injection		K2		$36.42
J1569	Gammagard liquid injection		K2		$38.13
J1570	Ganciclovir sodium injection		N1		
J1571	Hepagam b im injection		K2		$50.43

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J1572	Flebogamma injection		K2		$35.79
J1573	Hepagam b intravenous, inj		K2		$50.43
J1580	Garamycin gentamicin inj		N1		
J1590	Gatifloxacin injection		N1		
J1595	Injection glatiramer acetate		K2		$93.19
J1599	Ivig non-lyophilized, NOS	NI	N1		
J1600	Gold sodium thiomaleate inj		N1		
J1610	Glucagon hydrochloride/1 MG		K2		$85.12
J1620	Gonadorelin hydroch/ 100 mcg	CH	N1		
J1626	Granisetron hcl injection		N1		
J1630	Haloperidol injection		N1		
J1631	Haloperidol decanoate inj		N1		
J1640	Hemin, 1 mg		K2		$8.41
J1642	Inj heparin sodium per 10 u		N1		
J1644	Inj heparin sodium per 1000u		N1		
J1645	Dalteparin sodium		N1		
J1650	Inj enoxaparin sodium		N1		
J1652	Fondaparinux sodium	CH	N1		
J1655	Tinzaparin sodium injection		N1		
J1670	Tetanus immune globulin inj		K2		$230.10
J1680	Human fibrinogen conc inj		K2		$72.89
J1700	Hydrocortisone acetate inj		N1		
J1710	Hydrocortisone sodium ph inj		N1		
J1720	Hydrocortisone sodium succ i		N1		
J1730	Diazoxide injection		K2		$1.04
J1740	Ibandronate sodium injection		K2		$142.82
J1742	Ibutilide fumarate injection		K2		$188.42
J1743	Idursulfase injection		K2		$450.74
J1745	Infliximab injection		K2		$59.96
J1750	Inj iron dextran		K2		$11.88
J1756	Iron sucrose injection		K2		$0.36
J1785	Injection imiglucerase /unit	CH	D5		
J1786	Imuglucerase injection	NI	K2		$41.58
J1790	Droperidol injection		N1		
J1800	Propranolol injection		N1		
J1815	Insulin injection		N1		

ADDENDUM BB.—FINAL ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J1817	Insulin for insulin pump use	CH	N1		
J1830	Interferon beta-1b / .25 MG		K2		$182.83
J1835	Itraconazole injection	CH	N1		
J1840	Kanamycin sulfate 500 MG inj		N1		
J1850	Kanamycin sulfate 75 MG inj		N1		
J1885	Ketorolac tromethamine inj		N1		
J1890	Cephalothin sodium injection		N1		
J1930	Lanreotide injection		K2		$29.75
J1931	Laronidase injection		K2		$25.31
J1940	Furosemide injection		N1		
J1945	Lepirudin		K2		$277.67
J1950	Leuprolide acetate /3.75 MG		K2		$520.49
J1953	Levetiracetam injection	CH	N1		
J1956	Levofloxacin injection		N1		
J1960	Levorphanol tartrate inj		N1		
J1980	Hyoscyamine sulfate inj		N1		
J1990	Chlordiazepoxide injection		N1		
J2001	Lidocaine injection		N1		
J2010	Lincomycin injection		N1		
J2020	Linezolid injection		K2		$33.05
J2060	Lorazepam injection		N1		
J2150	Mannitol injection		N1		
J2170	Mecasermin injection	CH	K2		$20.37
J2175	Meperidine hydrochl /100 MG		N1		
J2180	Meperidine/promethazine inj		N1		
J2185	Meropenem		N1		
J2210	Methylergonovin maleate inj		N1		
J2248	Micafungin sodium injection		K2		$1.06
J2250	Inj midazolam hydrochloride		N1		
J2260	Inj milrinone lactate / 5 MG		N1		
J2270	Morphine sulfate injection		N1		
J2271	Morphine so4 injection 100mg		N1		
J2275	Morphine sulfate injection		N1		
J2278	Ziconotide injection		K2		$6.54
J2280	Inj, moxifloxacin 100 mg		N1		
J2300	Inj nalbuphine hydrochloride		N1		

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J2310	Inj naloxone hydrochloride		N1		
J2315	Naltrexone, depot form		K2		$2.36
J2320	Nandrolone decanoate 50 MG		K2		$9.27
J2321	Nandrolone decanoate 100 MG	CH	D5		
J2322	Nandrolone decanoate 200 MG	CH	D5		
J2323	Natalizumab injection		K2		$8.68
J2325	Nesiritide injection		K2		$39.90
J2353	Octreotide injection, depot		K2		$110.99
J2354	Octreotide inj, non-depot		N1		
J2355	Oprelvekin injection		K2		$242.29
J2357	Omalizumab injection		K2		$20.19
J2358	Olanzapine long-acting inj	NI	K2		$2.73
J2360	Orphenadrine injection		N1		
J2370	Phenylephrine hcl injection		N1		
J2400	Chloroprocaine hcl injection		N1		
J2405	Ondansetron hcl injection		N1		
J2410	Oxymorphone hcl injection		N1		
J2425	Palifermin injection		K2		$11.25
J2426	Paliperidone palmitate inj	NI	K2		$6.52
J2430	Pamidronate disodium /30 MG	CH	N1		
J2440	Papaverin hcl injection		N1		
J2469	Palonosetron hcl		K2		$18.23
J2501	Paricalcitol		N1		
J2503	Pegaptanib sodium injection		K2		$1,011.14
J2504	Pegademase bovine, 25 iu		K2		$245.00
J2505	Injection, pegfilgrastim 6mg		K2		$2,441.95
J2510	Penicillin g procaine inj		K2		$11.59
J2513	Pentastarch 10% solution		K2		$160.29
J2515	Pentobarbital sodium inj		N1		
J2540	Penicillin g potassium inj		N1		
J2543	Piperacillin/tazobactam		N1		
J2550	Promethazine hcl injection		N1		
J2560	Phenobarbital sodium inj		N1		
J2562	Plerixafor injection		K2		$281.67
J2590	Oxytocin injection		N1		
J2597	Inj desmopressin acetate		N1		

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J2650	Prednisolone acetate inj		N1		
J2670	Tolazoline hcl injection		N1		
J2675	Inj progesterone per 50 MG		N1		
J2680	Fluphenazine decanoate 25 MG		N1		
J2690	Procainamide hcl injection		N1		
J2700	Oxacillin sodium injeciton		K2		$2.18
J2710	Neostigmine methylsilfte inj		N1		
J2720	Inj protamine sulfate/10 MG		N1		
J2724	Protein c concentrate		K2		$12.43
J2725	Inj protirelin per 250 mcg		N1		
J2730	Pralidoxime chloride inj		K2		$89.82
J2760	Phentolaine mesylate inj		N1		
J2765	Metoclopramide hcl injection		N1		
J2770	Quinupristin/dalfopristin		K2		$158.36
J2778	Ranibizumab injection		K2		$401.39
J2780	Ranitidine hydrochloride inj		N1		
J2783	Rasburicase		K2		$177.57
J2785	Regadenoson injection		K2		$50.80
J2788	Rho d immune globulin 50 mcg		K2		$22.45
J2790	Rho d immune globulin inj		K2		$83.54
J2791	Rhophylac injection		K2		$5.13
J2792	Rho(D) immune globulin h, sd		K2		$17.25
J2793	Rilonacept injection		K2		$23.86
J2794	Risperidone, long acting		K2		$5.00
J2795	Ropivacaine HCl injection		N1		
J2796	Romiplostim injection		K2		$44.71
J2800	Methocarbamol injection		N1		
J2805	Sincalide injection		K2		$71.95
J2810	Inj theophylline per 40 MG		N1		
J2820	Sargramostim injection		K2		$23.65
J2850	Inj secretin synthetic human		K2		$27.23
J2910	Aurothioglucose injeciton		N1		
J2916	Na ferric gluconate complex		N1		
J2920	Methylprednisolone injection		N1		
J2930	Methylprednisolone injection		N1		
J2940	Somatrem injection	CH	N1		

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J2941	Somatropin injection		K2		$57.51
J2950	Promazine hcl injection		N1		
J2993	Reteplase injection		K2		$1,300.11
J2995	Inj streptokinase /250000 IU		K2		$47.57
J2997	Alteplase recombinant		K2		$38.34
J3000	Streptomycin injection		N1		
J3010	Fentanyl citrate injeciton		N1		
J3030	Sumatriptan succinate / 6 MG	CH	N1		
J3070	Pentazocine injection		N1		
J3095	Televancin injection	NI	K2		$1.87
J3101	Tenecteplase injection		K2		$47.18
J3105	Terbutaline sulfate inj		N1		
J3120	Testosterone enanthate inj		N1		
J3130	Testosterone enanthate inj		N1		
J3140	Testosterone suspension inj		N1		
J3150	Testosteron propionate inj		N1		
J3230	Chlorpromazine hcl injection		N1		
J3240	Thyrotropin injection		K2		$1,043.12
J3243	Tigecycline injection		K2		$1.23
J3246	Tirofiban HCl		K2		$7.96
J3250	Trimethobenzamide hcl inj		N1		
J3260	Tobramycin sulfate injection		N1		
J3262	Tocilizumab injection	NI	K2		$3.48
J3265	Injection torsemide 10 mg/ml		N1		
J3280	Thiethylperazine maleate inj		N1		
J3285	Treprostinil injection		K2		$59.92
J3300	Triamcinolone A inj PRS-free		K2		$3.19
J3301	Triamcinolone acet inj NOS		N1		
J3302	Triamcinolone diacetate inj		N1		
J3303	Triamcinolone hexacetonl inj		N1		
J3305	Inj trimetrexate glucoronate	CH	N1		
J3310	Perphenazine injeciton	CH	K2		$30.91
J3315	Triptorelin pamoate		K2		$180.22
J3350	Urea injection	CH	K2		$82.18
J3355	Urofollitropin, 75 iu		K2		$59.28
J3357	Ustekinumab injection	NI	K2		$107.11

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J3360	Diazepam injection		N1		
J3364	Urokinase 5000 IU injection		N1		
J3365	Urokinase 250,000 IU inj		K2		$453.41
J3370	Vancomycin hcl injection		N1		
J3385	Velaglucerase alfa	NI	K2		$350.60
J3396	Verteporfin injection		K2		$9.49
J3410	Hydroxyzine hcl injection		N1		
J3411	Thiamine hcl 100 mg		N1		
J3415	Pyridoxine hcl 100 mg		N1		
J3420	Vitamin b12 injection		N1		
J3430	Vitamin k phytonadione inj		N1		
J3465	Injection, voriconazole		K2		$5.88
J3470	Hyaluronidase injection		N1		
J3471	Ovine, up to 999 USP units		N1		
J3472	Ovine, 1000 USP units		N1		
J3473	Hyaluronidase recombinant		N1		
J3475	Inj magnesium sulfate		N1		
J3480	Inj potassium chloride		N1		
J3485	Zidovudine		N1		
J3486	Ziprasidone mesylate		N1		
J3487	Zoledronic acid		K2		$220.99
J3488	Reclast injection		K2		$220.55
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		
J7184	Wilate injection	NI	K2		$71.19

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J7185	Xyntha inj		K2		$1.05
J7186	Antihemophilic viii/vwf comp		K2		$0.91
J7187	Humate-P, inj		K2		$0.87
J7189	Factor viia		K2		$1.36
J7190	Factor viii		K2		$0.88
J7191	Factor VIII (porcine)		K2		$1.17
J7192	Factor viii recombinant NOS		K2		$1.09
J7193	Factor IX non-recombinant		K2		$0.89
J7194	Factor ix complex		K2		$0.88
J7195	Factor IX recombinant		K2		$1.11
J7196	Antithrombin recombinant	NI	K2		$2.93
J7197	Antithrombin iii injection		K2		$2.51
J7198	Anti-inhibitor		K2		$1.58
J7308	Aminolevulinic acid hcl top		K2		$137.64
J7309	Methyl aminolevulinate, top	NI	K2		$0.72
J7310	Ganciclovir long act implant		K2		$16,800.00
J7311	Fluocinolone acetonide implt		K2		$19,162.50
J7312	Dexamethasone intra implant	NI	K2		$196.10
J7321	Hyalgan/supartz inj per dose		K2		$89.67
J7323	Euflexxa inj per dose		K2		$125.97
J7324	Orthovisc inj per dose		K2		$173.45
J7325	Synvisc or Synvisc-One		K2		$11.83
J7335	Capsaicin 8% patch	NI	K2		$25.55
J7500	Azathioprine oral 50mg		N1		
J7501	Azathioprine parenteral		K2		$102.84
J7502	Cyclosporine oral 100 mg	CH	N1		
J7504	Lymphocyte immune globulin		K2		$492.26
J7505	Monoclonal antibodies		K2		$1,122.83
J7506	Prednisone oral		N1		
J7507	Tacrolimus oral per 1 MG	CH	N1		
J7509	Methylprednisolone oral		N1		
J7510	Prednisolone oral per 5 mg		N1		
J7511	Antithymocyte globuln rabbit		K2		$413.57
J7513	Daclizumab, parenteral		K2		$521.38
J7515	Cyclosporine oral 25 mg	CH	N1		
J7516	Cyclosporin parenteral 250mg	CH	N1		

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J7517	Mycophenolate mofetil oral	CH	N1		
J7518	Mycophenolic acid		N1		
J7520	Sirolimus, oral	CH	N1		
J7525	Tacrolimus injection		K2		$138.17
J7599	Immunosuppressive drug noc		N1		
J7674	Methacholine chloride, neb		N1		
J7799	Non-inhalation drug for DME		N1		
J8501	Oral aprepitant		K2		$5.79
J8510	Oral busulfan	CH	K2		$3.66
J8520	Capecitabine, oral, 150 mg		K2		$6.78
J8521	Capecitabine, oral, 500 mg		K2		$22.37
J8530	Cyclophosphamide oral 25 MG		N1		
J8540	Oral dexamethasone		N1		
J8560	Etoposide oral 50 MG		K2		$28.21
J8562	Oral fludarabine phosphate	NI	K2		$80.14
J8597	Antiemetic drug oral NOS		N1		
J8600	Melphalan oral 2 MG		N1		
J8610	Methotrexate oral 2.5 MG		N1		
J8650	Nabilone oral		N1		
J8700	Temozolomide		K2		$9.07
J8705	Topotecan oral		K2		$77.10
J9000	Doxorubicin hcl injection		N1		
J9001	Doxorubicin hcl liposome inj		K2		$482.21
J9010	Alemtuzumab injection		K2		$567.94
J9015	Aldesleukin injection		K2		$913.37
J9017	Arsenic trioxide injection		K2		$36.90
J9020	Asparaginase injection		K2		$62.87
J9025	Azacitidine injection		K2		$5.08
J9027	Clofarabine injection		K2		$114.32
J9031	Bcg live intravesical vac		K2		$113.85
J9033	Bendamustine injection		K2		$18.33
J9035	Bevacizumab injection		K2		$57.89
J9040	Bleomycin sulfate injection		N1		
J9041	Bortezomib injection		K2		$38.92
J9045	Carboplatin injection		N1		
J9050	Carmustine injection		K2		$174.22

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J9055	Cetuximab injection		K2		$49.27
J9060	Cisplatin 10 MG injection		N1		
J9062	Cisplatin 50 MG injection	CH	D5		
J9065	Inj cladribine per 1 MG		K2		$24.10
J9070	Cyclophosphamide 100 MG inj		N1		
J9080	Cyclophosphamide 200 MG inj	CH	D5		
J9090	Cyclophosphamide 500 MG inj	CH	D5		
J9091	Cyclophosphamide 1.0 grm inj	CH	D5		
J9092	Cyclophosphamide 2.0 grm inj	CH	D5		
J9093	Cyclophosphamide lyophilized	CH	D5		
J9094	Cyclophosphamide lyophilized	CH	D5		
J9095	Cyclophosphamide lyophilized	CH	D5		
J9096	Cyclophosphamide lyophilized	CH	D5		
J9097	Cyclophosphamide lyophilized	CH	D5		
J9098	Cytarabine liposome inj		K2		$466.07
J9100	Cytarabine hcl 100 MG inj		N1		
J9110	Cytarabine hcl 500 MG inj	CH	D5		
J9120	Dactinomycin injection		K2		$586.82
J9130	Dacarbazine 100 mg inj		N1		
J9140	Dacarbazine 200 MG inj	CH	D5		
J9150	Daunorubicin injection		K2		$15.35
J9151	Daunorubicin citrate inj		K2		$57.12
J9155	Degarelix injection		K2		$2.52
J9160	Denileukin diftitox inj		K2		$1,526.44
J9165	Diethylstilbestrol injection	CH	N1		
J9171	Docetaxel injection		K2		$17.84
J9175	Elliotts b solution per ml		N1		
J9178	Inj, epirubicin hcl, 2 mg		K2		$1.78
J9181	Etoposide injection		N1		
J9185	Fludarabine phosphate inj		K2		$138.26
J9190	Fluorouracil injection		N1		
J9200	Floxuridine injection		K2		$41.33
J9201	Gemcitabine hcl injection		K2		$146.95
J9202	Goserelin acetate implant		K2		$192.46
J9206	Irinotecan injection		K2		$6.07
J9207	Ixabepilone injection		K2		$63.14

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J9208	Ifosfomide injection		K2		$33.82
J9209	Mesna injection	CH	N1		
J9211	Idarubicin hcl injection		K2		$102.98
J9212	Interferon alfacon-1 inj		K2		$6.49
J9213	Interferon alfa-2a inj	CH	N1		
J9214	Interferon alfa-2b inj		K2		$15.91
J9215	Interferon alfa-n3 inj		K2		$18.06
J9216	Interferon gamma 1-b inj		K2		$426.87
J9217	Leuprolide acetate suspnsion		K2		$206.25
J9218	Leuprolide acetate injeciton		K2		$4.74
J9219	Leuprolide acetate implant		K2		$4,774.35
J9225	Vantas implant		K2		$1,470.47
J9226	Supprelin LA implant		K2		$15,141.06
J9230	Mechlorethamine hcl inj		K2		$153.01
J9245	Inj melphalan hydrochl 50 MG		K2		$1,388.61
J9250	Methotrexate sodium inj		N1		
J9260	Methotrexate sodium inj		N1		
J9261	Nelarabine injection		K2		$108.42
J9263	Oxaliplatin		K2		$4.67
J9264	Paclitaxel protein bound		K2		$9.30
J9265	Paclitaxel injection	CH	K2		$7.38
J9266	Pegaspargase injection		K2		$2,460.13
J9268	Pentostatin injection		K2		$1,217.22
J9270	Plicamycin (mithramycin) inj		N1		
J9280	Mitomycin 5 MG inj		K2		$20.57
J9290	Mitomycin 20 MG inj	CH	D5		
J9291	Mitomycin 40 MG inj	CH	D5		
J9293	Mitoxantrone hydrochl / 5 MG		K2		$40.45
J9300	Gemtuzumab ozogamicin inj		K2		$2,660.02
J9302	Ofatumumab injection	NI	K2		$45.47
J9303	Panitumumab injection		K2		$86.56
J9305	Pemetrexed injection		K2		$50.96
J9307	Pralatrexate injection	NI	K2		$165.63
J9310	Rituximab injection		K2		$588.27
J9315	Romidepsin injection	NI	K2		$219.30
J9320	Streptozocin injection		K2		$275.09

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HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
J9328	Temozolomide injection		K2		$4.90
J9330	Temsirolimus injection		K2		$50.35
J9340	Thiotepa injection		K2		$113.01
J9350	Topotecan injection	CH	D5		
J9351	Topotecan injection	NI	K2		$27.01
J9355	Trastuzumab injection		K2		$67.64
J9357	Valrubicin injection		K2		$954.10
J9360	Vinblastine sulfate inj		N1		
J9370	Vincristine sulfate 1 MG inj		N1		
J9375	Vincristine sulfate 2 MG inj	CH	D5		
J9380	Vincristine sulfate 5 MG inj	CH	D5		
J9390	Vinorelbine tartrate inj		N1		
J9395	Injection, Fulvestrant		K2		$82.23
J9600	Porfimer sodium injection		K2		$2,907.23
J9999	Chemotherapy drug		N1		
L8600	Implant breast silicone/eq		N1		
L8603	Collagen imp urinary 2.5 ml		N1		
L8604	Dextranomer/hyaluronic acid		N1		
L8606	Synthetic implnt urinary 1ml		N1		
L8609	Artificial cornea		N1		
L8610	Ocular implant		N1		
L8612	Aqueous shunt prosthesis		N1		
L8613	Ossicular implant		N1		
L8614	Cochlear device		N1		
L8630	Metacarpophalangeal implant		N1		
L8631	MCP joint repl 2 pc or more		N1		
L8641	Metatarsal joint implant		N1		
L8642	Hallux implant		N1		
L8658	Interphalangeal joint spacer		N1		
L8659	Interphalangeal joint repl		N1		
L8670	Vascular graft, synthetic		N1		
L8682	Implt neurostim radiofq rec		N1		
L8690	Aud osseo dev, int/ext comp		N1		
L8699	Prosthetic implant NOS		N1		
P9041	Albumin (human),5%, 50ml		K2		$20.37
P9045	Albumin (human), 5%, 250 ml		K2		$67.07

ADDENDUM BB.—FINAL ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
P9046	Albumin (human), 25%, 20 ml		K2		$29.16
P9047	Albumin (human), 25%, 50ml		K2		$70.39
Q0138	Ferumoxytol, non-esrd		K2		$0.77
Q0163	Diphenhydramine HCl 50mg		N1		
Q0164	Prochlorperazine maleate 5mg		N1		
Q0166	Granisetron hcl 1 mg oral		N1		
Q0167	Dronabinol 2.5mg oral		N1		
Q0169	Promethazine HCl 12.5mg oral		N1		
Q0171	Chlorpromazine HCl 10mg oral		N1		
Q0173	Trimethobenzamide HCl 250mg		N1		
Q0175	Perphenazine 4mg oral		N1		
Q0177	Hydroxyzine pamoate 25mg		N1		
Q0179	Ondansetron hcl 8 mg oral		N1		
Q0180	Dolasetron mesylate oral		N1		
Q0515	Sermorelin acetate injection		K2		$1.78
Q1003	Ntiol category 3		L6		
Q2004	Bladder calculi irrig sol	CH	N1		
Q2009	Fosphenytoin inj PE		N1		
Q2017	Teniposide, 50 mg		K2		$320.61
Q2025	Oral fludarabine phosphate	CH	D5		
Q2035**	Afluria vacc, 3 yrs & >, im	NI	L1		
Q2036**	Flulaval vacc, 3 yrs & >, im	NI	L1		
Q2037**	Fluvirin vacc, 3 yrs & >, im	NI	L1		
Q2038**	Fluzone vacc, 3 yrs & >, im	NI	L1		
Q2039**	NOS flu vacc, 3 yrs & >, im	NI	L1		
Q3025	IM inj interferon beta 1-a		K2		$212.28
Q4100	Skin substitute, NOS		N1		
Q4101	Apligraf		K2		$33.77
Q4102	Oasis wound matrix		K2		$4.38
Q4103	Oasis burn matrix		K2		$4.38
Q4104	Integra BMWD		K2		$14.91
Q4105	Integra DRT		K2		$10.13
Q4106	Dermagraft		K2		$39.73
Q4107	Graftjacket		K2		$94.23
Q4108	Integra matrix		K2		$19.04
Q4109	Tissuemend skin sub	CH	D5		

ADDENDUM BB.—FINAL ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Final CY 2011 Comment Indicator	Final CY 2011 Payment Indicator	Final CY 2011 Payment Weight	Final CY 2011 Payment
Q4110	Primatrix		K2		$34.71
Q4111	Gammagraft		K2		$7.03
Q4112	Cymetra injectable		K2		$350.04
Q4113	Graftjacket xpress		K2		$350.04
Q4114	Integra flowable wound matri		K2		$948.50
Q4115	Alloskin		K2		$6.63
Q4116	Alloderm		K2		$32.31
Q4118	Matristem micromatrix	NI	K2		$1.80
Q4121	Theraskin	NI	K2		$21.27
Q9951	LOCM >= 400 mg/ml iodine,1ml		N1		
Q9953	Inj Fe-based MR contrast,1ml		N1		
Q9954	Oral MR contrast, 100 ml		N1		
Q9955	Inj perflexane lip micros,ml		N1		
Q9956	Inj octafluoropropane mic,ml		N1		
Q9957	Inj perflutren lip micros,ml		N1		
Q9958	HOCM <=149 mg/ml iodine, 1ml		N1		
Q9959	HOCM 150-199mg/ml iodine,1ml		N1		
Q9960	HOCM 200-249mg/ml iodine,1ml		N1		
Q9961	HOCM 250-299mg/ml iodine,1ml		N1		
Q9962	HOCM 300-349mg/ml iodine,1ml		N1		
Q9963	HOCM 350-399mg/ml iodine,1ml		N1		
Q9964	HOCM>= 400mg/ml iodine, 1ml		N1		
Q9965	LOCM 100-199mg/ml iodine,1ml		N1		
Q9966	LOCM 200-299mg/ml iodine,1ml		N1		
Q9967	LOCM 300-399mg/ml iodine,1ml		N1		
Q9968	Visualization adjunct		K2		$1.44
V2630	Anter chamber intraocul lens		N1		
V2631	Iris support intraoclr lens		N1		
V2632	Post chmbr intraocular lens		N1		
V2785	Corneal tissue processing		F4		
V2790	Amniotic membrane		N1		

ADDENDUM D1.—FINAL OPPS PAYMENT STATUS INDICATORS FOR CY 2011

Indicator	Item/Code/Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital • Diagnostic Mammography • Screening Mammography	Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS. Not subject to deductible or coinsurance. Not subject to deductible or coinsurance.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. • May be paid by fiscal intermediaries/MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.

ADDENDUM D1.—FINAL OPPS PAYMENT STATUS INDICATORS FOR CY 2011		
Indicator	**Item/Code/Service**	**OPPS Payment Status**
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: • That are not covered by any Medicare outpatient benefit based on statutory exclusion. • That are not covered by any Medicare outpatient benefit for reasons other than statutory exclusion. • That are not recognized by Medicare for outpatient claims but for which an alternate code for the same item or service may be available. • For which separate payment is not provided on outpatient claims.	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines	Not paid under OPPS. Paid at reasonable cost.
G	Pass-Through Drugs and Biologicals	Paid under OPPS; separate APC payment.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to copayment.
K	Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals	Paid under OPPS; separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary/MAC	Not paid under OPPS.
N	Items and Services Packaged into APC Rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; per diem APC payment.

ADDENDUM D1.—FINAL OPPS PAYMENT STATUS INDICATORS FOR CY 2011		
Indicator	**Item/Code/Service**	**OPPS Payment Status**
Q1	STVX-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S," "T," "V," or "X." (2) In all other circumstances, payment is made through a separate APC payment.
Q2	T-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T." (2) In all other circumstances, payment is made through a separate APC payment.
Q3	Codes That May Be Paid Through a Composite APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service. (2) In all other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
R	Blood and Blood Products	Paid under OPPS; separate APC payment.
S	Significant Procedure, Not Discounted When Multiple	Paid under OPPS; separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; separate APC payment.

ADDENDUM D1.—FINAL OPPS PAYMENT STATUS INDICATORS FOR CY 2011		
Indicator	**Item/Code/Service**	**OPPS Payment Status**
U	Brachytherapy Sources	Paid under OPPS; separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; separate APC payment.
X	Ancillary Services	Paid under OPPS; separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

ADDENDUM DD1.—FINAL ASC PAYMENT INDICATORS FOR CY 2011	
Indicator	**Payment Indicator Definition**
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
D5	Deleted/discontinued code; no payment made.
F4	Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost.
G2	Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
H2	Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
H8	Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate.
J7	OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
J8	Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate.
K2	Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
K7	Unclassified drugs and biologicals; payment contractor-priced.
L1	Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.
L6	New Technology Intraocular Lens (NTIOL); special payment.
N1	Packaged service/item; no separate payment made.
P2	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
R2	Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.

ADDENDUM DD1.—FINAL ASC PAYMENT INDICATORS FOR CY 2011	
Indicator	**Payment Indicator Definition**
Z2	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
Z3	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

ADDENDUM D2.—FINAL OPPS COMMENT INDICATORS FOR CY 2011	
Comment Indicator	**Descriptor**
NI	New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year as compared to current calendar year, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.
CH	Active HCPCS code in current year and next calendar year, status indicator and/or APC assignment has changed; or active HCPCS code that will be discontinued at the end of the current calendar year.

ADDENDUM DD2.—FINAL ASC COMMENT INDICATORS FOR CY 2011	
CI	**Comment Indicator Meanings**
CH	Active HCPCS code in current year and next calendar year, payment indicator assignment has changed; or active HCPCS code that is newly recognized as payable in ASC; or active HCPCS code that is discontinued at the end of the current calendar year.
NI	New code, interim payment indicator assignment; comments will be accepted on the interim payment assignment for the new code.

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	**Short Descriptor**	**SI**	**CI**
00176	Anesth pharyngeal surgery	C	
00192	Anesth facial bone surgery	C	
00211	Anesth cran surg hemotoma	C	
00214	Anesth skull drainage	C	
00215	Anesth skull repair/fract	C	
00452	Anesth surgery of shoulder	C	
00474	Anesth surgery of rib(s)	C	
00524	Anesth chest drainage	C	
00540	Anesth chest surgery	C	
00542	Anesth release of lung	C	
00546	Anesth lung chest wall surg	C	
00560	Anesth heart surg w/o pump	C	
00561	Anesth heart surg < 1 yr	C	
00562	Anesth hrt surg w/pmp age 1+	C	
00567	Anesth cabg w/pump	C	
00580	Anesth heart/lung transplnt	C	
00604	Anesth sitting procedure	C	
00622	Anesth removal of nerves	C	
00632	Anesth removal of nerves	C	
00670	Anesth spine cord surgery	C	
00792	Anesth hemorr/excise liver	C	
00794	Anesth pancreas removal	C	
00796	Anesth for liver transplant	C	
00802	Anesth fat layer removal	C	
00844	Anesth pelvis surgery	C	
00846	Anesth hysterectomy	C	
00848	Anesth pelvic organ surg	C	
00864	Anesth removal of bladder	C	
00865	Anesth removal of prostate	C	
00866	Anesth removal of adrenal	C	
00868	Anesth kidney transplant	C	
00882	Anesth major vein ligation	C	
00904	Anesth perineal surgery	C	
00908	Anesth removal of prostate	C	
00932	Anesth amputation of penis	C	
00934	Anesth penis nodes removal	C	
00936	Anesth penis nodes removal	C	
00944	Anesth vaginal hysterectomy	C	
01140	Anesth amputation at pelvis	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
01150	Anesth pelvic tumor surgery	C	
01212	Anesth hip disarticulation	C	
01214	Anesth hip arthroplasty	C	
01232	Anesth amputation of femur	C	
01234	Anesth radical femur surg	C	
01272	Anesth femoral artery surg	C	
01274	Anesth femoral embolectomy	C	
01402	Anesth knee arthroplasty	C	
01404	Anesth amputation at knee	C	
01442	Anesth knee artery surg	C	
01444	Anesth knee artery repair	C	
01486	Anesth ankle replacement	C	
01502	Anesth lwr leg embolectomy	C	
01634	Anesth shoulder joint amput	C	
01636	Anesth forequarter amput	C	
01638	Anesth shoulder replacement	C	
01652	Anesth shoulder vessel surg	C	
01654	Anesth shoulder vessel surg	C	
01656	Anesth arm-leg vessel surg	C	
01756	Anesth radical humerus surg	C	
01990	Support for organ donor	C	
11004	Debride genitalia & perineum	C	
11005	Debride abdom wall	C	
11006	Debride genit/per/abdom wall	C	
11008	Remove mesh from abd wall	C	
15756	Free myo/skin flap microvasc	C	
15757	Free skin flap microvasc	C	
15758	Free fascial flap microvasc	C	
16036	Escharotomy addl incision	C	
19271	Revision of chest wall	C	
19272	Extensive chest wall surgery	C	
19305	Mast radical	C	
19306	Mast rad urban type	C	
19361	Breast reconstr w/lat flap	C	
19364	Breast reconstruction	C	
19367	Breast reconstruction	C	
19368	Breast reconstruction	C	
19369	Breast reconstruction	C	
20661	Application of head brace	C	
20664	Application of halo	C	
20802	Replantation arm complete	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
20805	Replant forearm complete	C	
20808	Replantation hand complete	C	
20816	Replantation digit complete	C	
20824	Replantation thumb complete	C	
20827	Replantation thumb complete	C	
20838	Replantation foot complete	C	
20930	Sp bone algrft morsel add-on	C	NI
20931	Sp bone algrft struct add-on	C	
20936	Sp bone agrft local add-on	C	
20937	Sp bone agrft morsel add-on	C	
20938	Sp bone agrft struct add-on	C	
20955	Fibula bone graft microvasc	C	
20956	Iliac bone graft microvasc	C	
20957	Mt bone graft microvasc	C	
20962	Other bone graft microvasc	C	
20969	Bone/skin graft microvasc	C	
20970	Bone/skin graft iliac crest	C	
21045	Extensive jaw surgery	C	
21141	Reconstruct midface lefort	C	
21142	Reconstruct midface lefort	C	
21143	Reconstruct midface lefort	C	
21145	Reconstruct midface lefort	C	
21146	Reconstruct midface lefort	C	
21147	Reconstruct midface lefort	C	
21151	Reconstruct midface lefort	C	
21154	Reconstruct midface lefort	C	
21155	Reconstruct midface lefort	C	
21159	Reconstruct midface lefort	C	
21160	Reconstruct midface lefort	C	
21179	Reconstruct entire forehead	C	
21180	Reconstruct entire forehead	C	
21182	Reconstruct cranial bone	C	
21183	Reconstruct cranial bone	C	
21184	Reconstruct cranial bone	C	
21188	Reconstruction of midface	C	
21194	Reconst lwr jaw w/graft	C	
21196	Reconst lwr jaw w/fixation	C	
21247	Reconstruct lower jaw bone	C	
21255	Reconstruct lower jaw bone	C	
21268	Revise eye sockets	C	
21343	Treatment of sinus fracture	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
21344	Treatment of sinus fracture	C	
21346	Treat nose/jaw fracture	C	
21347	Treat nose/jaw fracture	C	
21348	Treat nose/jaw fracture	C	
21366	Treat cheek bone fracture	C	
21422	Treat mouth roof fracture	C	
21423	Treat mouth roof fracture	C	
21431	Treat craniofacial fracture	C	
21432	Treat craniofacial fracture	C	
21433	Treat craniofacial fracture	C	
21435	Treat craniofacial fracture	C	
21436	Treat craniofacial fracture	C	
21510	Drainage of bone lesion	C	
21615	Removal of rib	C	
21616	Removal of rib and nerves	C	
21620	Partial removal of sternum	C	
21627	Sternal debridement	C	
21630	Extensive sternum surgery	C	
21632	Extensive sternum surgery	C	
21705	Revision of neck muscle/rib	C	
21740	Reconstruction of sternum	C	
21750	Repair of sternum separation	C	
21810	Treatment of rib fracture(s)	C	
21825	Treat sternum fracture	C	
22010	I&d p-spine c/t/cerv-thor	C	
22015	I&d p-spine l/s/ls	C	
22110	Remove part of neck vertebra	C	
22112	Remove part thorax vertebra	C	
22114	Remove part lumbar vertebra	C	
22116	Remove extra spine segment	C	
22206	Cut spine 3 col thor	C	
22207	Cut spine 3 col lumb	C	
22208	Cut spine 3 col addl seg	C	
22210	Revision of neck spine	C	
22212	Revision of thorax spine	C	
22214	Revision of lumbar spine	C	
22216	Revise extra spine segment	C	
22220	Revision of neck spine	C	
22224	Revision of lumbar spine	C	
22226	Revise extra spine segment	C	
22318	Treat odontoid fx w/o graft	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
22319	Treat odontoid fx w/graft	C	
22325	Treat spine fracture	C	
22326	Treat neck spine fracture	C	
22327	Treat thorax spine fracture	C	
22328	Treat each add spine fx	C	
22532	Lat thorax spine fusion	C	
22533	Lat lumbar spine fusion	C	
22534	Lat thor/lumb addl seg	C	
22548	Neck spine fusion	C	
22551	Neck spine fuse&remove addl	C	NI
22552	Addl neck spine fusion	C	NI
22554	Neck spine fusion	C	
22556	Thorax spine fusion	C	
22558	Lumbar spine fusion	C	
22585	Additional spinal fusion	C	
22590	Spine & skull spinal fusion	C	
22595	Neck spinal fusion	C	
22600	Neck spine fusion	C	
22610	Thorax spine fusion	C	
22630	Lumbar spine fusion	C	
22632	Spine fusion extra segment	C	
22800	Fusion of spine	C	
22802	Fusion of spine	C	
22804	Fusion of spine	C	
22808	Fusion of spine	C	
22810	Fusion of spine	C	
22812	Fusion of spine	C	
22818	Kyphectomy 1-2 segments	C	
22819	Kyphectomy 3 or more	C	
22830	Exploration of spinal fusion	C	
22840	Insert spine fixation device	C	
22841	Insert spine fixation device	C	
22842	Insert spine fixation device	C	
22843	Insert spine fixation device	C	
22844	Insert spine fixation device	C	
22845	Insert spine fixation device	C	
22846	Insert spine fixation device	C	
22847	Insert spine fixation device	C	
22848	Insert pelv fixation device	C	
22849	Reinsert spinal fixation	C	
22850	Remove spine fixation device	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
22852	Remove spine fixation device	C	
22855	Remove spine fixation device	C	
22856	Cerv artific diskectomy	C	
22857	Lumbar artif diskectomy	C	
22861	Revise cerv artific disc	C	
22862	Revise lumbar artif disc	C	
22864	Remove cerv artif disc	C	
22865	Remove lumb artif disc	C	
23200	Resect clavicle tumor	C	
23210	Resect scapula tumor	C	
23220	Resect prox humerus tumor	C	
23332	Remove shoulder foreign body	C	
23472	Reconstruct shoulder joint	C	
23900	Amputation of arm & girdle	C	
23920	Amputation at shoulder joint	C	
24900	Amputation of upper arm	C	
24920	Amputation of upper arm	C	
24930	Amputation follow-up surgery	C	
24931	Amputate upper arm & implant	C	
24940	Revision of upper arm	C	
25900	Amputation of forearm	C	
25905	Amputation of forearm	C	
25915	Amputation of forearm	C	
25920	Amputate hand at wrist	C	
25924	Amputation follow-up surgery	C	
25927	Amputation of hand	C	
26551	Great toe-hand transfer	C	
26553	Single transfer toe-hand	C	
26554	Double transfer toe-hand	C	
26556	Toe joint transfer	C	
26992	Drainage of bone lesion	C	
27005	Incision of hip tendon	C	
27025	Incision of hip/thigh fascia	C	
27030	Drainage of hip joint	C	
27036	Excision of hip joint/muscle	C	
27054	Removal of hip joint lining	C	
27070	Part remove hip bone super	C	
27071	Part removal hip bone deep	C	
27075	Resect hip tumor	C	
27076	Resect hip tum incl acetabul	C	
27077	Resect hip tum w/innom bone	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
27078	Rsect hip tum incl femur	C	
27090	Removal of hip prosthesis	C	
27091	Removal of hip prosthesis	C	
27120	Reconstruction of hip socket	C	
27122	Reconstruction of hip socket	C	
27125	Partial hip replacement	C	
27130	Total hip arthroplasty	C	
27132	Total hip arthroplasty	C	
27134	Revise hip joint replacement	C	
27137	Revise hip joint replacement	C	
27138	Revise hip joint replacement	C	
27140	Transplant femur ridge	C	
27146	Incision of hip bone	C	
27147	Revision of hip bone	C	
27151	Incision of hip bones	C	
27156	Revision of hip bones	C	
27158	Revision of pelvis	C	
27161	Incision of neck of femur	C	
27165	Incision/fixation of femur	C	
27170	Repair/graft femur head/neck	C	
27175	Treat slipped epiphysis	C	
27176	Treat slipped epiphysis	C	
27177	Treat slipped epiphysis	C	
27178	Treat slipped epiphysis	C	
27181	Treat slipped epiphysis	C	
27185	Revision of femur epiphysis	C	
27187	Reinforce hip bones	C	
27222	Treat hip socket fracture	C	
27226	Treat hip wall fracture	C	
27227	Treat hip fracture(s)	C	
27228	Treat hip fracture(s)	C	
27232	Treat thigh fracture	C	
27236	Treat thigh fracture	C	
27240	Treat thigh fracture	C	
27244	Treat thigh fracture	C	
27245	Treat thigh fracture	C	
27248	Treat thigh fracture	C	
27253	Treat hip dislocation	C	
27254	Treat hip dislocation	C	
27258	Treat hip dislocation	C	
27259	Treat hip dislocation	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
27268	Cltx thigh fx w/mnpj	C	
27269	Optx thigh fx	C	
27280	Fusion of sacroiliac joint	C	
27282	Fusion of pubic bones	C	
27284	Fusion of hip joint	C	
27286	Fusion of hip joint	C	
27290	Amputation of leg at hip	C	
27295	Amputation of leg at hip	C	
27303	Drainage of bone lesion	C	
27365	Resect femur/knee tumor	C	
27445	Revision of knee joint	C	
27447	Total knee arthroplasty	C	
27448	Incision of thigh	C	
27450	Incision of thigh	C	
27454	Realignment of thigh bone	C	
27455	Realignment of knee	C	
27457	Realignment of knee	C	
27465	Shortening of thigh bone	C	
27466	Lengthening of thigh bone	C	
27468	Shorten/lengthen thighs	C	
27470	Repair of thigh	C	
27472	Repair/graft of thigh	C	
27477	Surgery to stop leg growth	C	
27485	Surgery to stop leg growth	C	
27486	Revise/replace knee joint	C	
27487	Revise/replace knee joint	C	
27488	Removal of knee prosthesis	C	
27495	Reinforce thigh	C	
27506	Treatment of thigh fracture	C	
27507	Treatment of thigh fracture	C	
27511	Treatment of thigh fracture	C	
27513	Treatment of thigh fracture	C	
27514	Treatment of thigh fracture	C	
27519	Treat thigh fx growth plate	C	
27535	Treat knee fracture	C	
27536	Treat knee fracture	C	
27540	Treat knee fracture	C	
27556	Treat knee dislocation	C	
27557	Treat knee dislocation	C	
27558	Treat knee dislocation	C	
27580	Fusion of knee	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
27590	Amputate leg at thigh	C	
27591	Amputate leg at thigh	C	
27592	Amputate leg at thigh	C	
27596	Amputation follow-up surgery	C	
27598	Amputate lower leg at knee	C	
27645	Resect tibia tumor	C	
27646	Resect fibula tumor	C	
27702	Reconstruct ankle joint	C	
27703	Reconstruction ankle joint	C	
27712	Realignment of lower leg	C	
27715	Revision of lower leg	C	
27724	Repair/graft of tibia	C	
27725	Repair of lower leg	C	
27727	Repair of lower leg	C	
27880	Amputation of lower leg	C	
27881	Amputation of lower leg	C	
27882	Amputation of lower leg	C	
27886	Amputation follow-up surgery	C	
27888	Amputation of foot at ankle	C	
28800	Amputation of midfoot	C	
31225	Removal of upper jaw	C	
31230	Removal of upper jaw	C	
31290	Nasal/sinus endoscopy surg	C	
31291	Nasal/sinus endoscopy surg	C	
31360	Removal of larynx	C	
31365	Removal of larynx	C	
31367	Partial removal of larynx	C	
31368	Partial removal of larynx	C	
31370	Partial removal of larynx	C	
31375	Partial removal of larynx	C	
31380	Partial removal of larynx	C	
31382	Partial removal of larynx	C	
31390	Removal of larynx & pharynx	C	
31395	Reconstruct larynx & pharynx	C	
31584	Treat larynx fracture	C	
31587	Revision of larynx	C	
31725	Clearance of airways	C	
31760	Repair of windpipe	C	
31766	Reconstruction of windpipe	C	
31770	Repair/graft of bronchus	C	
31775	Reconstruct bronchus	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
31780	Reconstruct windpipe	C	
31781	Reconstruct windpipe	C	
31786	Remove windpipe lesion	C	
31800	Repair of windpipe injury	C	
31805	Repair of windpipe injury	C	
32035	Exploration of chest	C	
32036	Exploration of chest	C	
32095	Biopsy through chest wall	C	
32100	Exploration/biopsy of chest	C	
32110	Explore/repair chest	C	
32120	Re-exploration of chest	C	
32124	Explore chest free adhesions	C	
32140	Removal of lung lesion(s)	C	
32141	Remove/treat lung lesions	C	
32150	Removal of lung lesion(s)	C	
32151	Remove lung foreign body	C	
32160	Open chest heart massage	C	
32200	Drain open lung lesion	C	
32215	Treat chest lining	C	
32220	Release of lung	C	
32225	Partial release of lung	C	
32310	Removal of chest lining	C	
32320	Free/remove chest lining	C	
32402	Open biopsy chest lining	C	
32440	Removal of lung	C	
32442	Sleeve pneumonectomy	C	
32445	Removal of lung	C	
32480	Partial removal of lung	C	
32482	Bilobectomy	C	
32484	Segmentectomy	C	
32486	Sleeve lobectomy	C	
32488	Completion pneumonectomy	C	
32491	Lung volume reduction	C	
32500	Partial removal of lung	C	
32501	Repair bronchus add-on	C	
32503	Resect apical lung tumor	C	
32504	Resect apical lung tum/chest	C	
32540	Removal of lung lesion	C	
32650	Thoracoscopy surgical	C	
32651	Thoracoscopy surgical	C	
32652	Thoracoscopy surgical	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
32653	Thoracoscopy surgical	C	
32654	Thoracoscopy surgical	C	
32655	Thoracoscopy surgical	C	
32656	Thoracoscopy surgical	C	
32657	Thoracoscopy surgical	C	
32658	Thoracoscopy surgical	C	
32659	Thoracoscopy surgical	C	
32660	Thoracoscopy surgical	C	
32661	Thoracoscopy surgical	C	
32662	Thoracoscopy surgical	C	
32663	Thoracoscopy surgical	C	
32664	Thoracoscopy surgical	C	
32665	Thoracoscopy surgical	C	
32800	Repair lung hernia	C	
32810	Close chest after drainage	C	
32815	Close bronchial fistula	C	
32820	Reconstruct injured chest	C	
32850	Donor pneumonectomy	C	
32851	Lung transplant single	C	
32852	Lung transplant with bypass	C	
32853	Lung transplant double	C	
32854	Lung transplant with bypass	C	
32855	Prepare donor lung single	C	
32856	Prepare donor lung double	C	
32900	Removal of rib(s)	C	
32905	Revise & repair chest wall	C	
32906	Revise & repair chest wall	C	
32940	Revision of lung	C	
32997	Total lung lavage	C	
33015	Incision of heart sac	C	
33020	Incision of heart sac	C	
33025	Incision of heart sac	C	
33030	Partial removal of heart sac	C	
33031	Partial removal of heart sac	C	
33050	Removal of heart sac lesion	C	
33120	Removal of heart lesion	C	
33130	Removal of heart lesion	C	
33140	Heart revascularize (tmr)	C	
33141	Heart tmr w/other procedure	C	
33202	Insert epicard eltrd open	C	
33203	Insert epicard eltrd endo	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
33236	Remove electrode/thoracotomy	C	
33237	Remove electrode/thoracotomy	C	
33238	Remove electrode/thoracotomy	C	
33243	Remove eltrd/thoracotomy	C	
33250	Ablate heart dysrhythm focus	C	
33251	Ablate heart dysrhythm focus	C	
33254	Ablate atria lmtd	C	
33255	Ablate atria w/o bypass ext	C	
33256	Ablate atria w/bypass exten	C	
33257	Ablate atria lmtd add-on	C	
33258	Ablate atria x10sv add-on	C	
33259	Ablate atria w/bypass add-on	C	
33261	Ablate heart dysrhythm focus	C	
33265	Ablate atria lmtd endo	C	
33266	Ablate atria x10sv endo	C	
33300	Repair of heart wound	C	
33305	Repair of heart wound	C	
33310	Exploratory heart surgery	C	
33315	Exploratory heart surgery	C	
33320	Repair major blood vessel(s)	C	
33321	Repair major vessel	C	
33322	Repair major blood vessel(s)	C	
33330	Insert major vessel graft	C	
33332	Insert major vessel graft	C	
33335	Insert major vessel graft	C	
33400	Repair of aortic valve	C	
33401	Valvuloplasty open	C	
33403	Valvuloplasty w/cp bypass	C	
33404	Prepare heart-aorta conduit	C	
33405	Replacement of aortic valve	C	
33406	Replacement of aortic valve	C	
33410	Replacement of aortic valve	C	
33411	Replacement of aortic valve	C	
33412	Replacement of aortic valve	C	
33413	Replacement of aortic valve	C	
33414	Repair of aortic valve	C	
33415	Revision subvalvular tissue	C	
33416	Revise ventricle muscle	C	
33417	Repair of aortic valve	C	
33420	Revision of mitral valve	C	
33422	Revision of mitral valve	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
33425	Repair of mitral valve	C	
33426	Repair of mitral valve	C	
33427	Repair of mitral valve	C	
33430	Replacement of mitral valve	C	
33460	Revision of tricuspid valve	C	
33463	Valvuloplasty tricuspid	C	
33464	Valvuloplasty tricuspid	C	
33465	Replace tricuspid valve	C	
33468	Revision of tricuspid valve	C	
33470	Revision of pulmonary valve	C	
33471	Valvotomy pulmonary valve	C	
33472	Revision of pulmonary valve	C	
33474	Revision of pulmonary valve	C	
33475	Replacement pulmonary valve	C	
33476	Revision of heart chamber	C	
33478	Revision of heart chamber	C	
33496	Repair prosth valve clot	C	
33500	Repair heart vessel fistula	C	
33501	Repair heart vessel fistula	C	
33502	Coronary artery correction	C	
33503	Coronary artery graft	C	
33504	Coronary artery graft	C	
33505	Repair artery w/tunnel	C	
33506	Repair artery translocation	C	
33507	Repair art intramural	C	
33510	Cabg vein single	C	
33511	Cabg vein two	C	
33512	Cabg vein three	C	
33513	Cabg vein four	C	
33514	Cabg vein five	C	
33516	Cabg vein six or more	C	
33517	Cabg artery-vein single	C	
33518	Cabg artery-vein two	C	
33519	Cabg artery-vein three	C	
33521	Cabg artery-vein four	C	
33522	Cabg artery-vein five	C	
33523	Cabg art-vein six or more	C	
33530	Coronary artery bypass/reop	C	
33533	Cabg arterial single	C	
33534	Cabg arterial two	C	
33535	Cabg arterial three	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
33536	Cabg arterial four or more	C	
33542	Removal of heart lesion	C	
33545	Repair of heart damage	C	
33548	Restore/remodel ventricle	C	
33572	Open coronary endarterectomy	C	
33600	Closure of valve	C	
33602	Closure of valve	C	
33606	Anastomosis/artery-aorta	C	
33608	Repair anomaly w/conduit	C	
33610	Repair by enlargement	C	
33611	Repair double ventricle	C	
33612	Repair double ventricle	C	
33615	Repair modified fontan	C	
33617	Repair single ventricle	C	
33619	Repair single ventricle	C	
33620	Apply r&l pulm art bands	C	NI
33621	Transthor cath for stent	C	NI
33622	Redo compl cardiac anomaly	C	NI
33641	Repair heart septum defect	C	
33645	Revision of heart veins	C	
33647	Repair heart septum defects	C	
33660	Repair of heart defects	C	
33665	Repair of heart defects	C	
33670	Repair of heart chambers	C	
33675	Close mult vsd	C	
33676	Close mult vsd w/resection	C	
33677	Cl mult vsd w/rem pul band	C	
33681	Repair heart septum defect	C	
33684	Repair heart septum defect	C	
33688	Repair heart septum defect	C	
33690	Reinforce pulmonary artery	C	
33692	Repair of heart defects	C	
33694	Repair of heart defects	C	
33697	Repair of heart defects	C	
33702	Repair of heart defects	C	
33710	Repair of heart defects	C	
33720	Repair of heart defect	C	
33722	Repair of heart defect	C	
33724	Repair venous anomaly	C	
33726	Repair pul venous stenosis	C	
33730	Repair heart-vein defect(s)	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
33732	Repair heart-vein defect	C	
33735	Revision of heart chamber	C	
33736	Revision of heart chamber	C	
33737	Revision of heart chamber	C	
33750	Major vessel shunt	C	
33755	Major vessel shunt	C	
33762	Major vessel shunt	C	
33764	Major vessel shunt & graft	C	
33766	Major vessel shunt	C	
33767	Major vessel shunt	C	
33768	Cavopulmonary shunting	C	
33770	Repair great vessels defect	C	
33771	Repair great vessels defect	C	
33774	Repair great vessels defect	C	
33775	Repair great vessels defect	C	
33776	Repair great vessels defect	C	
33777	Repair great vessels defect	C	
33778	Repair great vessels defect	C	
33779	Repair great vessels defect	C	
33780	Repair great vessels defect	C	
33781	Repair great vessels defect	C	
33782	Nikaidoh proc	C	
33783	Nikaidoh proc w/ostia implt	C	
33786	Repair arterial trunk	C	
33788	Revision of pulmonary artery	C	
33800	Aortic suspension	C	
33802	Repair vessel defect	C	
33803	Repair vessel defect	C	
33813	Repair septal defect	C	
33814	Repair septal defect	C	
33820	Revise major vessel	C	
33822	Revise major vessel	C	
33824	Revise major vessel	C	
33840	Remove aorta constriction	C	
33845	Remove aorta constriction	C	
33851	Remove aorta constriction	C	
33852	Repair septal defect	C	
33853	Repair septal defect	C	
33860	Ascending aortic graft	C	
33863	Ascending aortic graft	C	
33864	Ascending aortic graft	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
33870	Transverse aortic arch graft	C	
33875	Thoracic aortic graft	C	
33877	Thoracoabdominal graft	C	
33880	Endovasc taa repr incl subcl	C	
33881	Endovasc taa repr w/o subcl	C	
33883	Insert endovasc prosth taa	C	
33884	Endovasc prosth taa add-on	C	
33886	Endovasc prosth delayed	C	
33889	Artery transpose/endovas taa	C	
33891	Car-car bp grft/endovas taa	C	
33910	Remove lung artery emboli	C	
33915	Remove lung artery emboli	C	
33916	Surgery of great vessel	C	
33917	Repair pulmonary artery	C	
33920	Repair pulmonary atresia	C	
33922	Transect pulmonary artery	C	
33924	Remove pulmonary shunt	C	
33925	Rpr pul art unifocal w/o cpb	C	
33926	Repr pul art unifocal w/cpb	C	
33930	Removal of donor heart/lung	C	
33933	Prepare donor heart/lung	C	
33935	Transplantation heart/lung	C	
33940	Removal of donor heart	C	
33944	Prepare donor heart	C	
33945	Transplantation of heart	C	
33960	External circulation assist	C	
33961	External circulation assist	C	
33967	Insert ia percut device	C	
33968	Remove aortic assist device	C	
33970	Aortic circulation assist	C	
33971	Aortic circulation assist	C	
33973	Insert balloon device	C	
33974	Remove intra-aortic balloon	C	
33975	Implant ventricular device	C	
33976	Implant ventricular device	C	
33977	Remove ventricular device	C	
33978	Remove ventricular device	C	
33979	Insert intracorporeal device	C	
33980	Remove intracorporeal device	C	
33981	Replace vad pump ext	C	
33982	Replace vad intra w/o bp	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
33983	Replace vad intra w/bp	C	
34001	Removal of artery clot	C	
34051	Removal of artery clot	C	
34151	Removal of artery clot	C	
34401	Removal of vein clot	C	
34451	Removal of vein clot	C	
34502	Reconstruct vena cava	C	
34800	Endovas aaa repr w/sm tube	C	
34802	Endovas aaa repr w/2-p part	C	
34803	Endovas aaa repr w/3-p part	C	
34804	Endovas aaa repr w/1-p part	C	
34805	Endovas aaa repr w/long tube	C	
34806	Aneurysm press sensor add-on	C	
34808	Endovas iliac a device addon	C	
34812	Xpose for endoprosth femorl	C	
34813	Femoral endovas graft add-on	C	
34820	Xpose for endoprosth iliac	C	
34825	Endovasc extend prosth init	C	
34826	Endovasc exten prosth addl	C	
34830	Open aortic tube prosth repr	C	
34831	Open aortoiliac prosth repr	C	
34832	Open aortofemor prosth repr	C	
34833	Xpose for endoprosth iliac	C	
34834	Xpose endoprosth brachial	C	
34900	Endovasc iliac repr w/graft	C	
35001	Repair defect of artery	C	
35002	Repair artery rupture neck	C	
35005	Repair defect of artery	C	
35013	Repair artery rupture arm	C	
35021	Repair defect of artery	C	
35022	Repair artery rupture chest	C	
35045	Repair defect of arm artery	C	
35081	Repair defect of artery	C	
35082	Repair artery rupture aorta	C	
35091	Repair defect of artery	C	
35092	Repair artery rupture aorta	C	
35102	Repair defect of artery	C	
35103	Repair artery rupture groin	C	
35111	Repair defect of artery	C	
35112	Repair artery rupture spleen	C	
35121	Repair defect of artery	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
35122	Repair artery rupture belly	C	
35131	Repair defect of artery	C	
35132	Repair artery rupture groin	C	
35141	Repair defect of artery	C	
35142	Repair artery rupture thigh	C	
35151	Repair defect of artery	C	
35152	Repair artery rupture knee	C	
35182	Repair blood vessel lesion	C	
35189	Repair blood vessel lesion	C	
35211	Repair blood vessel lesion	C	
35216	Repair blood vessel lesion	C	
35221	Repair blood vessel lesion	C	
35241	Repair blood vessel lesion	C	
35246	Repair blood vessel lesion	C	
35251	Repair blood vessel lesion	C	
35271	Repair blood vessel lesion	C	
35276	Repair blood vessel lesion	C	
35281	Repair blood vessel lesion	C	
35301	Rechanneling of artery	C	
35302	Rechanneling of artery	C	
35303	Rechanneling of artery	C	
35304	Rechanneling of artery	C	
35305	Rechanneling of artery	C	
35306	Rechanneling of artery	C	
35311	Rechanneling of artery	C	
35331	Rechanneling of artery	C	
35341	Rechanneling of artery	C	
35351	Rechanneling of artery	C	
35355	Rechanneling of artery	C	
35361	Rechanneling of artery	C	
35363	Rechanneling of artery	C	
35371	Rechanneling of artery	C	
35372	Rechanneling of artery	C	
35390	Reoperation carotid add-on	C	
35400	Angioscopy	C	
35450	Repair arterial blockage	C	
35452	Repair arterial blockage	C	
35501	Artery bypass graft	C	
35506	Artery bypass graft	C	
35508	Artery bypass graft	C	
35509	Artery bypass graft	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
35510	Artery bypass graft	C	
35511	Artery bypass graft	C	
35512	Artery bypass graft	C	
35515	Artery bypass graft	C	
35516	Artery bypass graft	C	
35518	Artery bypass graft	C	
35521	Artery bypass graft	C	
35522	Artery bypass graft	C	
35523	Artery bypass graft	C	
35525	Artery bypass graft	C	
35526	Artery bypass graft	C	
35531	Artery bypass graft	C	
35533	Artery bypass graft	C	
35535	Artery bypass graft	C	
35536	Artery bypass graft	C	
35537	Artery bypass graft	C	
35538	Artery bypass graft	C	
35539	Artery bypass graft	C	
35540	Artery bypass graft	C	
35548	Artery bypass graft	C	
35549	Artery bypass graft	C	
35551	Artery bypass graft	C	
35556	Artery bypass graft	C	
35558	Artery bypass graft	C	
35560	Artery bypass graft	C	
35563	Artery bypass graft	C	
35565	Artery bypass graft	C	
35566	Artery bypass graft	C	
35570	Artery bypass graft	C	
35571	Artery bypass graft	C	
35583	Vein bypass graft	C	
35585	Vein bypass graft	C	
35587	Vein bypass graft	C	
35600	Harvest art for cabg add-on	C	
35601	Artery bypass graft	C	
35606	Artery bypass graft	C	
35612	Artery bypass graft	C	
35616	Artery bypass graft	C	
35621	Artery bypass graft	C	
35623	Bypass graft not vein	C	
35626	Artery bypass graft	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
35631	Artery bypass graft	C	
35632	Artery bypass graft	C	
35633	Artery bypass graft	C	
35634	Artery bypass graft	C	
35636	Artery bypass graft	C	
35637	Artery bypass graft	C	
35638	Artery bypass graft	C	
35642	Artery bypass graft	C	
35645	Artery bypass graft	C	
35646	Artery bypass graft	C	
35647	Artery bypass graft	C	
35650	Artery bypass graft	C	
35651	Artery bypass graft	C	
35654	Artery bypass graft	C	
35656	Artery bypass graft	C	
35661	Artery bypass graft	C	
35663	Artery bypass graft	C	
35665	Artery bypass graft	C	
35666	Artery bypass graft	C	
35671	Artery bypass graft	C	
35681	Composite bypass graft	C	
35682	Composite bypass graft	C	
35683	Composite bypass graft	C	
35691	Arterial transposition	C	
35693	Arterial transposition	C	
35694	Arterial transposition	C	
35695	Arterial transposition	C	
35697	Reimplant artery each	C	
35700	Reoperation bypass graft	C	
35701	Exploration carotid artery	C	
35721	Exploration femoral artery	C	
35741	Exploration popliteal artery	C	
35800	Explore neck vessels	C	
35820	Explore chest vessels	C	
35840	Explore abdominal vessels	C	
35870	Repair vessel graft defect	C	
35901	Excision graft neck	C	
35905	Excision graft thorax	C	
35907	Excision graft abdomen	C	
36660	Insertion catheter artery	C	
36822	Insertion of cannula(s)	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
36823	Insertion of cannula(s)	C	
37140	Revision of circulation	C	
37145	Revision of circulation	C	
37160	Revision of circulation	C	
37180	Revision of circulation	C	
37181	Splice spleen/kidney veins	C	
37182	Insert hepatic shunt (tips)	C	
37215	Transcath stent cca w/eps	C	
37616	Ligation of chest artery	C	
37617	Ligation of abdomen artery	C	
37618	Ligation of extremity artery	C	
37660	Revision of major vein	C	
37788	Revascularization penis	C	
38100	Removal of spleen total	C	
38101	Removal of spleen partial	C	
38102	Removal of spleen total	C	
38115	Repair of ruptured spleen	C	
38380	Thoracic duct procedure	C	
38381	Thoracic duct procedure	C	
38382	Thoracic duct procedure	C	
38562	Removal pelvic lymph nodes	C	
38564	Removal abdomen lymph nodes	C	
38724	Removal of lymph nodes neck	C	
38746	Remove thoracic lymph nodes	C	
38747	Remove abdominal lymph nodes	C	
38765	Remove groin lymph nodes	C	
38770	Remove pelvis lymph nodes	C	
38780	Remove abdomen lymph nodes	C	
39000	Exploration of chest	C	
39010	Exploration of chest	C	
39200	Removal chest lesion	C	
39220	Removal chest lesion	C	
39499	Chest procedure	C	
39501	Repair diaphragm laceration	C	
39503	Repair of diaphragm hernia	C	
39540	Repair of diaphragm hernia	C	
39541	Repair of diaphragm hernia	C	
39545	Revision of diaphragm	C	
39560	Resect diaphragm simple	C	
39561	Resect diaphragm complex	C	
39599	Diaphragm surgery procedure	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
41130	Partial removal of tongue	C	
41135	Tongue and neck surgery	C	
41140	Removal of tongue	C	
41145	Tongue removal neck surgery	C	
41150	Tongue mouth jaw surgery	C	
41153	Tongue mouth neck surgery	C	
41155	Tongue jaw & neck surgery	C	
42426	Excise parotid gland/lesion	C	
42845	Extensive surgery of throat	C	
42894	Revision of pharyngeal walls	C	
42953	Repair throat esophagus	C	
42961	Control throat bleeding	C	
42971	Control nose/throat bleeding	C	
43045	Incision of esophagus	C	
43100	Excision of esophagus lesion	C	
43101	Excision of esophagus lesion	C	
43107	Removal of esophagus	C	
43108	Removal of esophagus	C	
43112	Removal of esophagus	C	
43113	Removal of esophagus	C	
43116	Partial removal of esophagus	C	
43117	Partial removal of esophagus	C	
43118	Partial removal of esophagus	C	
43121	Partial removal of esophagus	C	
43122	Partial removal of esophagus	C	
43123	Partial removal of esophagus	C	
43124	Removal of esophagus	C	
43135	Removal of esophagus pouch	C	
43279	Lap myotomy heller	C	
43281	Lap paraesophag hern repair	C	
43282	Lap paraesoph her rpr w/mesh	C	
43283	Lap esoph lengthening	C	NI
43300	Repair of esophagus	C	
43305	Repair esophagus and fistula	C	
43310	Repair of esophagus	C	
43312	Repair esophagus and fistula	C	
43313	Esophagoplasty congenital	C	
43314	Tracheo-esophagoplasty cong	C	
43320	Fuse esophagus & stomach	C	
43325	Revise esophagus & stomach	C	
43327	Esoph fundoplasty lap	C	NI

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
43328	Esoph fundoplasty thor	C	NI
43330	Esophagomyotomy abdominal	C	
43331	Esophagomyotomy thoracic	C	
43332	Transab esoph hiat hern rpr	C	NI
43333	Transab esoph hiat hern rpr	C	NI
43334	Transthor diaphrag hern rpr	C	NI
43335	Transthor diaphrag hern rpr	C	NI
43336	Thorabd diaphr hern repair	C	NI
43337	Thorabd diaphr hern repair	C	NI
43338	Esoph lengthening	C	NI
43340	Fuse esophagus & intestine	C	
43341	Fuse esophagus & intestine	C	
43350	Surgical opening esophagus	C	
43351	Surgical opening esophagus	C	
43352	Surgical opening esophagus	C	
43360	Gastrointestinal repair	C	
43361	Gastrointestinal repair	C	
43400	Ligate esophagus veins	C	
43401	Esophagus surgery for veins	C	
43405	Ligate/staple esophagus	C	
43410	Repair esophagus wound	C	
43415	Repair esophagus wound	C	
43425	Repair esophagus opening	C	
43460	Pressure treatment esophagus	C	
43496	Free jejunum flap microvasc	C	
43500	Surgical opening of stomach	C	
43501	Surgical repair of stomach	C	
43502	Surgical repair of stomach	C	
43520	Incision of pyloric muscle	C	
43605	Biopsy of stomach	C	
43610	Excision of stomach lesion	C	
43611	Excision of stomach lesion	C	
43620	Removal of stomach	C	
43621	Removal of stomach	C	
43622	Removal of stomach	C	
43631	Removal of stomach partial	C	
43632	Removal of stomach partial	C	
43633	Removal of stomach partial	C	
43634	Removal of stomach partial	C	
43635	Removal of stomach partial	C	
43640	Vagotomy & pylorus repair	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
43641	Vagotomy & pylorus repair	C	
43644	Lap gastric bypass/roux-en-y	C	
43645	Lap gastr bypass incl smll i	C	
43770	Lap place gastr adj device	C	
43771	Lap revise gastr adj device	C	
43772	Lap rmvl gastr adj device	C	
43773	Lap replace gastr adj device	C	
43774	Lap rmvl gastr adj all parts	C	
43800	Reconstruction of pylorus	C	
43810	Fusion of stomach and bowel	C	
43820	Fusion of stomach and bowel	C	
43825	Fusion of stomach and bowel	C	
43832	Place gastrostomy tube	C	
43840	Repair of stomach lesion	C	
43843	Gastroplasty w/o v-band	C	
43845	Gastroplasty duodenal switch	C	
43846	Gastric bypass for obesity	C	
43847	Gastric bypass incl small i	C	
43848	Revision gastroplasty	C	
43850	Revise stomach-bowel fusion	C	
43855	Revise stomach-bowel fusion	C	
43860	Revise stomach-bowel fusion	C	
43865	Revise stomach-bowel fusion	C	
43880	Repair stomach-bowel fistula	C	
43881	Impl/redo electrd antrum	C	
43882	Revise/remove electrd antrum	C	
44005	Freeing of bowel adhesion	C	
44010	Incision of small bowel	C	
44015	Insert needle cath bowel	C	
44020	Explore small intestine	C	
44021	Decompress small bowel	C	
44025	Incision of large bowel	C	
44050	Reduce bowel obstruction	C	
44055	Correct malrotation of bowel	C	
44110	Excise intestine lesion(s)	C	
44111	Excision of bowel lesion(s)	C	
44120	Removal of small intestine	C	
44121	Removal of small intestine	C	
44125	Removal of small intestine	C	
44126	Enterectomy w/o taper cong	C	
44127	Enterectomy w/taper cong	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
44128	Enterectomy cong add-on	C	
44130	Bowel to bowel fusion	C	
44132	Enterectomy cadaver donor	C	
44133	Enterectomy live donor	C	
44135	Intestine transplnt cadaver	C	
44136	Intestine transplant live	C	
44137	Remove intestinal allograft	C	
44139	Mobilization of colon	C	
44140	Partial removal of colon	C	
44141	Partial removal of colon	C	
44143	Partial removal of colon	C	
44144	Partial removal of colon	C	
44145	Partial removal of colon	C	
44146	Partial removal of colon	C	
44147	Partial removal of colon	C	
44150	Removal of colon	C	
44151	Removal of colon/ileostomy	C	
44155	Removal of colon/ileostomy	C	
44156	Removal of colon/ileostomy	C	
44157	Colectomy w/ileoanal anast	C	
44158	Colectomy w/neo-rectum pouch	C	
44160	Removal of colon	C	
44187	Lap ileo/jejuno-stomy	C	
44188	Lap colostomy	C	
44202	Lap enterectomy	C	
44203	Lap resect s/intestine addl	C	
44204	Laparo partial colectomy	C	
44205	Lap colectomy part w/ileum	C	
44210	Laparo total proctocolectomy	C	
44211	Lap colectomy w/proctectomy	C	
44212	Laparo total proctocolectomy	C	
44227	Lap close enterostomy	C	
44300	Open bowel to skin	C	
44310	Ileostomy/jejunostomy	C	
44314	Revision of ileostomy	C	
44316	Devise bowel pouch	C	
44320	Colostomy	C	
44322	Colostomy with biopsies	C	
44345	Revision of colostomy	C	
44346	Revision of colostomy	C	
44602	Suture small intestine	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
44603	Suture small intestine	C	
44604	Suture large intestine	C	
44605	Repair of bowel lesion	C	
44615	Intestinal stricturoplasty	C	
44620	Repair bowel opening	C	
44625	Repair bowel opening	C	
44626	Repair bowel opening	C	
44640	Repair bowel-skin fistula	C	
44650	Repair bowel fistula	C	
44660	Repair bowel-bladder fistula	C	
44661	Repair bowel-bladder fistula	C	
44680	Surgical revision intestine	C	
44700	Suspend bowel w/prosthesis	C	
44715	Prepare donor intestine	C	
44720	Prep donor intestine/venous	C	
44721	Prep donor intestine/artery	C	
44800	Excision of bowel pouch	C	
44820	Excision of mesentery lesion	C	
44850	Repair of mesentery	C	
44899	Bowel surgery procedure	C	
44900	Drain app abscess open	C	
44960	Appendectomy	C	
45110	Removal of rectum	C	
45111	Partial removal of rectum	C	
45112	Removal of rectum	C	
45113	Partial proctectomy	C	
45114	Partial removal of rectum	C	
45116	Partial removal of rectum	C	
45119	Remove rectum w/reservoir	C	
45120	Removal of rectum	C	
45121	Removal of rectum and colon	C	
45123	Partial proctectomy	C	
45126	Pelvic exenteration	C	
45130	Excision of rectal prolapse	C	
45135	Excision of rectal prolapse	C	
45136	Excise ileoanal reservior	C	
45395	Lap removal of rectum	C	
45397	Lap remove rectum w/pouch	C	
45400	Laparoscopic proc	C	
45402	Lap proctopexy w/sig resect	C	
45540	Correct rectal prolapse	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
45550	Repair rectum/remove sigmoid	C	
45562	Exploration/repair of rectum	C	
45563	Exploration/repair of rectum	C	
45800	Repair rect/bladder fistula	C	
45805	Repair fistula w/colostomy	C	
45820	Repair rectourethral fistula	C	
45825	Repair fistula w/colostomy	C	
46705	Repair of anal stricture	C	
46710	Repr per/vag pouch sngl proc	C	
46712	Repr per/vag pouch dbl proc	C	
46715	Rep perf anoper fistu	C	
46716	Rep perf anoper/vestib fistu	C	
46730	Construction of absent anus	C	
46735	Construction of absent anus	C	
46740	Construction of absent anus	C	
46742	Repair of imperforated anus	C	
46744	Repair of cloacal anomaly	C	
46746	Repair of cloacal anomaly	C	
46748	Repair of cloacal anomaly	C	
46751	Repair of anal sphincter	C	
47010	Open drainage liver lesion	C	
47015	Inject/aspirate liver cyst	C	
47100	Wedge biopsy of liver	C	
47120	Partial removal of liver	C	
47122	Extensive removal of liver	C	
47125	Partial removal of liver	C	
47130	Partial removal of liver	C	
47133	Removal of donor liver	C	
47135	Transplantation of liver	C	
47136	Transplantation of liver	C	
47140	Partial removal donor liver	C	
47141	Partial removal donor liver	C	
47142	Partial removal donor liver	C	
47143	Prep donor liver whole	C	
47144	Prep donor liver 3-segment	C	
47145	Prep donor liver lobe split	C	
47146	Prep donor liver/venous	C	
47147	Prep donor liver/arterial	C	
47300	Surgery for liver lesion	C	
47350	Repair liver wound	C	
47360	Repair liver wound	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
47361	Repair liver wound	C	
47362	Repair liver wound	C	
47380	Open ablate liver tumor rf	C	
47381	Open ablate liver tumor cryo	C	
47400	Incision of liver duct	C	
47420	Incision of bile duct	C	
47425	Incision of bile duct	C	
47460	Incise bile duct sphincter	C	
47480	Incision of gallbladder	C	
47550	Bile duct endoscopy add-on	C	
47570	Laparo cholecystoenterostomy	C	
47600	Removal of gallbladder	C	
47605	Removal of gallbladder	C	
47610	Removal of gallbladder	C	
47612	Removal of gallbladder	C	
47620	Removal of gallbladder	C	
47700	Exploration of bile ducts	C	
47701	Bile duct revision	C	
47711	Excision of bile duct tumor	C	
47712	Excision of bile duct tumor	C	
47715	Excision of bile duct cyst	C	
47720	Fuse gallbladder & bowel	C	
47721	Fuse upper gi structures	C	
47740	Fuse gallbladder & bowel	C	
47741	Fuse gallbladder & bowel	C	
47760	Fuse bile ducts and bowel	C	
47765	Fuse liver ducts & bowel	C	
47780	Fuse bile ducts and bowel	C	
47785	Fuse bile ducts and bowel	C	
47800	Reconstruction of bile ducts	C	
47801	Placement bile duct support	C	
47802	Fuse liver duct & intestine	C	
47900	Suture bile duct injury	C	
48000	Drainage of abdomen	C	
48001	Placement of drain pancreas	C	
48020	Removal of pancreatic stone	C	
48100	Biopsy of pancreas open	C	
48105	Resect/debride pancreas	C	
48120	Removal of pancreas lesion	C	
48140	Partial removal of pancreas	C	
48145	Partial removal of pancreas	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
48146	Pancreatectomy	C	
48148	Removal of pancreatic duct	C	
48150	Partial removal of pancreas	C	
48152	Pancreatectomy	C	
48153	Pancreatectomy	C	
48154	Pancreatectomy	C	
48155	Removal of pancreas	C	
48400	Injection intraop add-on	C	
48500	Surgery of pancreatic cyst	C	
48510	Drain pancreatic pseudocyst	C	
48520	Fuse pancreas cyst and bowel	C	
48540	Fuse pancreas cyst and bowel	C	
48545	Pancreatorrhaphy	C	
48547	Duodenal exclusion	C	
48548	Fuse pancreas and bowel	C	
48551	Prep donor pancreas	C	
48552	Prep donor pancreas/venous	C	
48554	Transpl allograft pancreas	C	
48556	Removal allograft pancreas	C	
49000	Exploration of abdomen	C	
49002	Reopening of abdomen	C	
49010	Exploration behind abdomen	C	
49020	Drain abdominal abscess	C	
49040	Drain open abdom abscess	C	
49060	Drain open retrop abscess	C	
49062	Drain to peritoneal cavity	C	
49203	Exc abd tum 5 cm or less	C	
49204	Exc abd tum over 5 cm	C	
49205	Exc abd tum over 10 cm	C	
49215	Excise sacral spine tumor	C	
49220	Multiple surgery abdomen	C	
49255	Removal of omentum	C	
49412	Ins device for rt guide open	C	NI
49425	Insert abdomen-venous drain	C	
49428	Ligation of shunt	C	
49605	Repair umbilical lesion	C	
49606	Repair umbilical lesion	C	
49610	Repair umbilical lesion	C	
49611	Repair umbilical lesion	C	
49900	Repair of abdominal wall	C	
49904	Omental flap extra-abdom	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
49905	Omental flap intra-abdom	C	
49906	Free omental flap microvasc	C	
50010	Exploration of kidney	C	
50040	Drainage of kidney	C	
50045	Exploration of kidney	C	
50060	Removal of kidney stone	C	
50065	Incision of kidney	C	
50070	Incision of kidney	C	
50075	Removal of kidney stone	C	
50100	Revise kidney blood vessels	C	
50120	Exploration of kidney	C	
50125	Explore and drain kidney	C	
50130	Removal of kidney stone	C	
50135	Exploration of kidney	C	
50205	Renal biopsy open	C	
50220	Remove kidney open	C	
50225	Removal kidney open complex	C	
50230	Removal kidney open radical	C	
50234	Removal of kidney & ureter	C	
50236	Removal of kidney & ureter	C	
50240	Partial removal of kidney	C	
50250	Cryoablate renal mass open	C	
50280	Removal of kidney lesion	C	
50290	Removal of kidney lesion	C	
50300	Remove cadaver donor kidney	C	
50320	Remove kidney living donor	C	
50323	Prep cadaver renal allograft	C	
50325	Prep donor renal graft	C	
50327	Prep renal graft/venous	C	
50328	Prep renal graft/arterial	C	
50329	Prep renal graft/ureteral	C	
50340	Removal of kidney	C	
50360	Transplantation of kidney	C	
50365	Transplantation of kidney	C	
50370	Remove transplanted kidney	C	
50380	Reimplantation of kidney	C	
50400	Revision of kidney/ureter	C	
50405	Revision of kidney/ureter	C	
50500	Repair of kidney wound	C	
50520	Close kidney-skin fistula	C	
50525	Repair renal-abdomen fistula	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
50526	Repair renal-abdomen fistula	C	
50540	Revision of horseshoe kidney	C	
50545	Laparo radical nephrectomy	C	
50546	Laparoscopic nephrectomy	C	
50547	Laparo removal donor kidney	C	
50548	Laparo remove w/ureter	C	
50600	Exploration of ureter	C	
50605	Insert ureteral support	C	
50610	Removal of ureter stone	C	
50620	Removal of ureter stone	C	
50630	Removal of ureter stone	C	
50650	Removal of ureter	C	
50660	Removal of ureter	C	
50700	Revision of ureter	C	
50715	Release of ureter	C	
50722	Release of ureter	C	
50725	Release/revise ureter	C	
50728	Revise ureter	C	
50740	Fusion of ureter & kidney	C	
50750	Fusion of ureter & kidney	C	
50760	Fusion of ureters	C	
50770	Splicing of ureters	C	
50780	Reimplant ureter in bladder	C	
50782	Reimplant ureter in bladder	C	
50783	Reimplant ureter in bladder	C	
50785	Reimplant ureter in bladder	C	
50800	Implant ureter in bowel	C	
50810	Fusion of ureter & bowel	C	
50815	Urine shunt to intestine	C	
50820	Construct bowel bladder	C	
50825	Construct bowel bladder	C	
50830	Revise urine flow	C	
50840	Replace ureter by bowel	C	
50845	Appendico-vesicostomy	C	
50860	Transplant ureter to skin	C	
50900	Repair of ureter	C	
50920	Closure ureter/skin fistula	C	
50930	Closure ureter/bowel fistula	C	
50940	Release of ureter	C	
51525	Removal of bladder lesion	C	
51530	Removal of bladder lesion	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
51550	Partial removal of bladder	C	
51555	Partial removal of bladder	C	
51565	Revise bladder & ureter(s)	C	
51570	Removal of bladder	C	
51575	Removal of bladder & nodes	C	
51580	Remove bladder/revise tract	C	
51585	Removal of bladder & nodes	C	
51590	Remove bladder/revise tract	C	
51595	Remove bladder/revise tract	C	
51596	Remove bladder/create pouch	C	
51597	Removal of pelvic structures	C	
51800	Revision of bladder/urethra	C	
51820	Revision of urinary tract	C	
51840	Attach bladder/urethra	C	
51841	Attach bladder/urethra	C	
51865	Repair of bladder wound	C	
51900	Repair bladder/vagina lesion	C	
51920	Close bladder-uterus fistula	C	
51925	Hysterectomy/bladder repair	C	
51940	Correction of bladder defect	C	
51960	Revision of bladder & bowel	C	
51980	Construct bladder opening	C	
53415	Reconstruction of urethra	C	
53448	Remov/replc ur sphinctr comp	C	
54125	Removal of penis	C	
54130	Remove penis & nodes	C	
54135	Remove penis & nodes	C	
54390	Repair penis and bladder	C	
54411	Remov/replc penis pros comp	C	
54417	Remv/replc penis pros compl	C	
54430	Revision of penis	C	
54650	Orchiopexy (Fowler-Stephens)	C	
55605	Incise sperm duct pouch	C	
55650	Remove sperm duct pouch	C	
55801	Removal of prostate	C	
55810	Extensive prostate surgery	C	
55812	Extensive prostate surgery	C	
55815	Extensive prostate surgery	C	
55821	Removal of prostate	C	
55831	Removal of prostate	C	
55840	Extensive prostate surgery	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
55842	Extensive prostate surgery	C	
55845	Extensive prostate surgery	C	
55862	Extensive prostate surgery	C	
55865	Extensive prostate surgery	C	
55866	Laparo radical prostatectomy	C	
56630	Extensive vulva surgery	C	
56631	Extensive vulva surgery	C	
56632	Extensive vulva surgery	C	
56633	Extensive vulva surgery	C	
56634	Extensive vulva surgery	C	
56637	Extensive vulva surgery	C	
56640	Extensive vulva surgery	C	
57110	Remove vagina wall complete	C	
57111	Remove vagina tissue compl	C	
57112	Vaginectomy w/nodes compl	C	
57270	Repair of bowel pouch	C	
57280	Suspension of vagina	C	
57296	Revise vag graft open abd	C	
57305	Repair rectum-vagina fistula	C	
57307	Fistula repair & colostomy	C	
57308	Fistula repair transperine	C	
57311	Repair urethrovaginal lesion	C	
57531	Removal of cervix radical	C	
57540	Removal of residual cervix	C	
57545	Remove cervix/repair pelvis	C	
58140	Myomectomy abdom method	C	
58146	Myomectomy abdom complex	C	
58150	Total hysterectomy	C	
58152	Total hysterectomy	C	
58180	Partial hysterectomy	C	
58200	Extensive hysterectomy	C	
58210	Extensive hysterectomy	C	
58240	Removal of pelvis contents	C	
58267	Vag hyst w/urinary repair	C	
58275	Hysterectomy/revise vagina	C	
58280	Hysterectomy/revise vagina	C	
58285	Extensive hysterectomy	C	
58293	Vag hyst w/uro repair compl	C	
58400	Suspension of uterus	C	
58410	Suspension of uterus	C	
58520	Repair of ruptured uterus	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
58540	Revision of uterus	C	
58548	Lap radical hyst	C	
58605	Division of fallopian tube	C	
58611	Ligate oviduct(s) add-on	C	
58700	Removal of fallopian tube	C	
58720	Removal of ovary/tube(s)	C	
58740	Adhesiolysis tube ovary	C	
58750	Repair oviduct	C	
58752	Revise ovarian tube(s)	C	
58760	Fimbrioplasty	C	
58822	Drain ovary abscess percut	C	
58825	Transposition ovary(s)	C	
58940	Removal of ovary(s)	C	
58943	Removal of ovary(s)	C	
58950	Resect ovarian malignancy	C	
58951	Resect ovarian malignancy	C	
58952	Resect ovarian malignancy	C	
58953	Tah rad dissect for debulk	C	
58954	Tah rad debulk/lymph remove	C	
58956	Bso omentectomy w/tah	C	
58957	Resect recurrent gyn mal	C	
58958	Resect recur gyn mal w/lym	C	
58960	Exploration of abdomen	C	
59120	Treat ectopic pregnancy	C	
59121	Treat ectopic pregnancy	C	
59130	Treat ectopic pregnancy	C	
59135	Treat ectopic pregnancy	C	
59136	Treat ectopic pregnancy	C	
59140	Treat ectopic pregnancy	C	
59325	Revision of cervix	C	
59350	Repair of uterus	C	
59514	Cesarean delivery only	C	
59525	Remove uterus after cesarean	C	
59620	Attempted vbac delivery only	C	
59830	Treat uterus infection	C	
59850	Abortion	C	
59851	Abortion	C	
59852	Abortion	C	
59855	Abortion	C	
59856	Abortion	C	
59857	Abortion	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
60254	Extensive thyroid surgery	C	
60270	Removal of thyroid	C	
60505	Explore parathyroid glands	C	
60521	Removal of thymus gland	C	
60522	Removal of thymus gland	C	
60540	Explore adrenal gland	C	
60545	Explore adrenal gland	C	
60600	Remove carotid body lesion	C	
60605	Remove carotid body lesion	C	
60650	Laparoscopy adrenalectomy	C	
61105	Twist drill hole	C	
61107	Drill skull for implantation	C	
61108	Drill skull for drainage	C	
61120	Burr hole for puncture	C	
61140	Pierce skull for biopsy	C	
61150	Pierce skull for drainage	C	
61151	Pierce skull for drainage	C	
61154	Pierce skull & remove clot	C	
61156	Pierce skull for drainage	C	
61210	Pierce skull implant device	C	
61250	Pierce skull & explore	C	
61253	Pierce skull & explore	C	
61304	Open skull for exploration	C	
61305	Open skull for exploration	C	
61312	Open skull for drainage	C	
61313	Open skull for drainage	C	
61314	Open skull for drainage	C	
61315	Open skull for drainage	C	
61316	Implt cran bone flap to abdo	C	
61320	Open skull for drainage	C	
61321	Open skull for drainage	C	
61322	Decompressive craniotomy	C	
61323	Decompressive lobectomy	C	
61332	Explore/biopsy eye socket	C	
61333	Explore orbit/remove lesion	C	
61340	Subtemporal decompression	C	
61343	Incise skull (press relief)	C	
61345	Relieve cranial pressure	C	
61440	Incise skull for surgery	C	
61450	Incise skull for surgery	C	
61458	Incise skull for brain wound	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
61460	Incise skull for surgery	C	
61470	Incise skull for surgery	C	
61480	Incise skull for surgery	C	
61490	Incise skull for surgery	C	
61500	Removal of skull lesion	C	
61501	Remove infected skull bone	C	
61510	Removal of brain lesion	C	
61512	Remove brain lining lesion	C	
61514	Removal of brain abscess	C	
61516	Removal of brain lesion	C	
61517	Implt brain chemotx add-on	C	
61518	Removal of brain lesion	C	
61519	Remove brain lining lesion	C	
61520	Removal of brain lesion	C	
61521	Removal of brain lesion	C	
61522	Removal of brain abscess	C	
61524	Removal of brain lesion	C	
61526	Removal of brain lesion	C	
61530	Removal of brain lesion	C	
61531	Implant brain electrodes	C	
61533	Implant brain electrodes	C	
61534	Removal of brain lesion	C	
61535	Remove brain electrodes	C	
61536	Removal of brain lesion	C	
61537	Removal of brain tissue	C	
61538	Removal of brain tissue	C	
61539	Removal of brain tissue	C	
61540	Removal of brain tissue	C	
61541	Incision of brain tissue	C	
61542	Removal of brain tissue	C	
61543	Removal of brain tissue	C	
61544	Remove & treat brain lesion	C	
61545	Excision of brain tumor	C	
61546	Removal of pituitary gland	C	
61548	Removal of pituitary gland	C	
61550	Release of skull seams	C	
61552	Release of skull seams	C	
61556	Incise skull/sutures	C	
61557	Incise skull/sutures	C	
61558	Excision of skull/sutures	C	
61559	Excision of skull/sutures	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
61563	Excision of skull tumor	C	
61564	Excision of skull tumor	C	
61566	Removal of brain tissue	C	
61567	Incision of brain tissue	C	
61570	Remove foreign body brain	C	
61571	Incise skull for brain wound	C	
61575	Skull base/brainstem surgery	C	
61576	Skull base/brainstem surgery	C	
61580	Craniofacial approach skull	C	
61581	Craniofacial approach skull	C	
61582	Craniofacial approach skull	C	
61583	Craniofacial approach skull	C	
61584	Orbitocranial approach/skull	C	
61585	Orbitocranial approach/skull	C	
61586	Resect nasopharynx skull	C	
61590	Infratemporal approach/skull	C	
61591	Infratemporal approach/skull	C	
61592	Orbitocranial approach/skull	C	
61595	Transtemporal approach/skull	C	
61596	Transcochlear approach/skull	C	
61597	Transcondylar approach/skull	C	
61598	Transpetrosal approach/skull	C	
61600	Resect/excise cranial lesion	C	
61601	Resect/excise cranial lesion	C	
61605	Resect/excise cranial lesion	C	
61606	Resect/excise cranial lesion	C	
61607	Resect/excise cranial lesion	C	
61608	Resect/excise cranial lesion	C	
61609	Transect artery sinus	C	
61610	Transect artery sinus	C	
61611	Transect artery sinus	C	
61612	Transect artery sinus	C	
61613	Remove aneurysm sinus	C	
61615	Resect/excise lesion skull	C	
61616	Resect/excise lesion skull	C	
61618	Repair dura	C	
61619	Repair dura	C	
61624	Transcath occlusion cns	C	
61630	Intracranial angioplasty	C	
61635	Intracran angioplsty w/stent	C	
61680	Intracranial vessel surgery	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
61682	Intracranial vessel surgery	C	
61684	Intracranial vessel surgery	C	
61686	Intracranial vessel surgery	C	
61690	Intracranial vessel surgery	C	
61692	Intracranial vessel surgery	C	
61697	Brain aneurysm repr complx	C	
61698	Brain aneurysm repr complx	C	
61700	Brain aneurysm repr simple	C	
61702	Inner skull vessel surgery	C	
61703	Clamp neck artery	C	
61705	Revise circulation to head	C	
61708	Revise circulation to head	C	
61710	Revise circulation to head	C	
61711	Fusion of skull arteries	C	
61735	Incise skull/brain surgery	C	
61750	Incise skull/brain biopsy	C	
61751	Brain biopsy w/ct/mr guide	C	
61760	Implant brain electrodes	C	
61850	Implant neuroelectrodes	C	
61860	Implant neuroelectrodes	C	
61863	Implant neuroelectrode	C	
61864	Implant neuroelectrde addl	C	
61867	Implant neuroelectrode	C	
61868	Implant neuroelectrde addl	C	
61870	Implant neuroelectrodes	C	
61875	Implant neuroelectrodes	C	
62005	Treat skull fracture	C	
62010	Treatment of head injury	C	
62100	Repair brain fluid leakage	C	
62115	Reduction of skull defect	C	
62116	Reduction of skull defect	C	
62117	Reduction of skull defect	C	
62120	Repair skull cavity lesion	C	
62121	Incise skull repair	C	
62140	Repair of skull defect	C	
62141	Repair of skull defect	C	
62142	Remove skull plate/flap	C	
62143	Replace skull plate/flap	C	
62145	Repair of skull & brain	C	
62146	Repair of skull with graft	C	
62147	Repair of skull with graft	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
62148	Retr bone flap to fix skull	C	
62161	Dissect brain w/scope	C	
62162	Remove colloid cyst w/scope	C	
62163	Neuroendoscopy w/fb removal	C	
62164	Remove brain tumor w/scope	C	
62165	Remove pituit tumor w/scope	C	
62180	Establish brain cavity shunt	C	
62190	Establish brain cavity shunt	C	
62192	Establish brain cavity shunt	C	
62200	Establish brain cavity shunt	C	
62201	Brain cavity shunt w/scope	C	
62220	Establish brain cavity shunt	C	
62223	Establish brain cavity shunt	C	
62256	Remove brain cavity shunt	C	
62258	Replace brain cavity shunt	C	
63043	Laminotomy addl cervical	C	
63044	Laminotomy addl lumbar	C	
63050	Cervical laminoplasty	C	
63051	C-laminoplasty w/graft/plate	C	
63077	Spine disk surgery thorax	C	
63078	Spine disk surgery thorax	C	
63081	Removal of vertebral body	C	
63082	Remove vertebral body add-on	C	
63085	Removal of vertebral body	C	
63086	Remove vertebral body add-on	C	
63087	Removal of vertebral body	C	
63088	Remove vertebral body add-on	C	
63090	Removal of vertebral body	C	
63091	Remove vertebral body add-on	C	
63101	Removal of vertebral body	C	
63102	Removal of vertebral body	C	
63103	Remove vertebral body add-on	C	
63170	Incise spinal cord tract(s)	C	
63172	Drainage of spinal cyst	C	
63173	Drainage of spinal cyst	C	
63180	Revise spinal cord ligaments	C	
63182	Revise spinal cord ligaments	C	
63185	Incise spinal column/nerves	C	
63190	Incise spinal column/nerves	C	
63191	Incise spinal column/nerves	C	
63194	Incise spinal column & cord	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
63195	Incise spinal column & cord	C	
63196	Incise spinal column & cord	C	
63197	Incise spinal column & cord	C	
63198	Incise spinal column & cord	C	
63199	Incise spinal column & cord	C	
63200	Release of spinal cord	C	
63250	Revise spinal cord vessels	C	
63251	Revise spinal cord vessels	C	
63252	Revise spinal cord vessels	C	
63265	Excise intraspinal lesion	C	
63266	Excise intraspinal lesion	C	
63267	Excise intraspinal lesion	C	
63268	Excise intraspinal lesion	C	
63270	Excise intraspinal lesion	C	
63271	Excise intraspinal lesion	C	
63272	Excise intraspinal lesion	C	
63273	Excise intraspinal lesion	C	
63275	Biopsy/excise spinal tumor	C	
63276	Biopsy/excise spinal tumor	C	
63277	Biopsy/excise spinal tumor	C	
63278	Biopsy/excise spinal tumor	C	
63280	Biopsy/excise spinal tumor	C	
63281	Biopsy/excise spinal tumor	C	
63282	Biopsy/excise spinal tumor	C	
63283	Biopsy/excise spinal tumor	C	
63285	Biopsy/excise spinal tumor	C	
63286	Biopsy/excise spinal tumor	C	
63287	Biopsy/excise spinal tumor	C	
63290	Biopsy/excise spinal tumor	C	
63295	Repair of laminectomy defect	C	
63300	Removal of vertebral body	C	
63301	Removal of vertebral body	C	
63302	Removal of vertebral body	C	
63303	Removal of vertebral body	C	
63304	Removal of vertebral body	C	
63305	Removal of vertebral body	C	
63306	Removal of vertebral body	C	
63307	Removal of vertebral body	C	
63308	Remove vertebral body add-on	C	
63700	Repair of spinal herniation	C	
63702	Repair of spinal herniation	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
63704	Repair of spinal herniation	C	
63706	Repair of spinal herniation	C	
63707	Repair spinal fluid leakage	C	
63709	Repair spinal fluid leakage	C	
63710	Graft repair of spine defect	C	
63740	Install spinal shunt	C	
64752	Incision of vagus nerve	C	
64755	Incision of stomach nerves	C	
64760	Incision of vagus nerve	C	
64809	Remove sympathetic nerves	C	
64818	Remove sympathetic nerves	C	
64866	Fusion of facial/other nerve	C	
64868	Fusion of facial/other nerve	C	
65273	Repair of eye wound	C	
69155	Extensive ear/neck surgery	C	
69535	Remove part of temporal bone	C	
69554	Remove ear lesion	C	
69950	Incise inner ear nerve	C	
75900	Intravascular cath exchange	C	
75952	Endovasc repair abdom aorta	C	
75953	Abdom aneurysm endovas rpr	C	
75954	Iliac aneurysm endovas rpr	C	
75956	Xray endovasc thor ao repr	C	
75957	Xray endovasc thor ao repr	C	
75958	Xray place prox ext thor ao	C	
75959	Xray place dist ext thor ao	C	
92970	Cardioassist internal	C	
92971	Cardioassist external	C	
92975	Dissolve clot heart vessel	C	
92992	Revision of heart chamber	C	
92993	Revision of heart chamber	C	
99190	Special pump services	C	
99191	Special pump services	C	
99192	Special pump services	C	
99356	Prolonged service inpatient	C	
99357	Prolonged service inpatient	C	
99462	Sbsq nb em per day hosp	C	
99468	Neonate crit care initial	C	
99469	Neonate crit care subsq	C	
99471	Ped critical care initial	C	
99472	Ped critical care subsq	C	

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
99475	Ped crit care age 2-5 init	C	
99476	Ped crit care age 2-5 subsq	C	
99477	Init day hosp neonate care	C	
99478	Ic lbw inf < 1500 gm subsq	C	
99479	Ic lbw inf 1500-2500 g subsq	C	
99480	Ic inf pbw 2501-5000 g subsq	C	
0048T	Implant ventricular device	C	
0050T	Removal circulation assist	C	
0051T	Implant total heart system	C	
0052T	Replace component heart syst	C	
0053T	Replace component heart syst	C	
0075T	Perq stent/chest vert art	C	
0076T	S&i stent/chest vert art	C	
0078T	Endovasc aort repr w/device	C	
0079T	Endovasc visc extnsn repr	C	
0080T	Endovasc aort repr rad s&i	C	
0081T	Endovasc visc extnsn s&i	C	
0092T	Artific disc addl	C	
0095T	Artific diskectomy addl	C	
0098T	Rev artific disc addl	C	
0157T	Open impl gast curve electrd	C	
0158T	Open remv gast curve electrd	C	
0163T	Lumb artif diskectomy addl	C	
0164T	Remove lumb artif disc addl	C	
0165T	Revise lumb artif disc addl	C	
0166T	Tcath vsd close w/o bypass	C	
0167T	Tcath vsd close w/bypass	C	
0169T	Place stereo cath brain	C	
0184T	Exc rectal tumor endoscopic	C	
0195T	Arthrod presac interbody	C	
0196T	Arthrod presac interbody eac	C	
0202T	Post vert arthrplst 1 lumbar	C	
0219T	Plmt post facet implt cerv	C	
0220T	Plmt post facet implt thor	C	
0235T	Trluml perip athrc visceral	C	NI
0254T	Evasc rpr iliac art bifur	C	NI
0255T	Evasc rpr iliac art bifr s&i	C	NI
0256T	Evasc aortic hrt valve	C	NI
0257T	Opn tthrc aortic hrt valve	C	NI
0258T	Aortic hrt valv w/o card byp	C	NI
0259T	Aortic hrt valve w/card byp	C	NI

ADDENDUM E.—HCPCS CODES THAT ARE PAID AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
G0341	Percutaneous islet celltrans	C	
G0342	Laparoscopy islet cell traus	C	
G0343	Laparotomy islet cell transp	C	
G0406	Telhealth inpt consult 15min	C	
G0407	Telheath inpt consult 25min	C	
G0408	Telhealth inpt consult 35min	C	
G0412	Open tx iliac spine uni/bil	C	
G0414	Pelvic ring fx treat int fix	C	
G0415	Open tx post pelvic fxcture	C	
G0425	Inpt telehealth consult 30m	C	
G0426	Inpt telehealth consult 50m	C	
G0427	Inpt telehealth con 70/>m	C	

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
010005	*	0.0326	MARSHALL	01470
010008		0.0365	CRENSHAW	01200
010010		0.0326	MARSHALL	01470
010012		0.0177	DE KALB	01240
010015		0.0055	CLARKE	01120
010021		0.0052	DALE	01220
010022	*	0.0595	CHEROKEE	01090
010025	*	0.0389	CHAMBERS	01080
010027		0.0026	COFFEE	01150
010029	*	0.0525	LEE	01400
010032		0.0309	RANDOLPH	01550
010035	*	0.0220	CULLMAN	01210
010040		0.0061	ETOWAH	01270
010045		0.0375	FAYETTE	01280
010046	*	0.0061	ETOWAH	01270
010047		0.0266	BUTLER	01060
010049		0.0026	COFFEE	01150

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
010052	*	0.0245	TALLAPOOSA	01610
010059	*	0.0071	LAWRENCE	01390
010061	*	0.0575	JACKSON	01350
010065	*	0.0245	TALLAPOOSA	01610
010083	*	0.0153	BALDWIN	01010
010091		0.0055	CLARKE	01120
010100	*	0.0153	BALDWIN	01010
010101	*	0.0188	TALLADEGA	01600
010109		0.0405	PICKENS	01530
010110		0.0450	BULLOCK	01050
010125		0.0425	WINSTON	01660
010128		0.0055	CLARKE	01120
010129		0.0153	BALDWIN	01010
010138		0.0089	SUMTER	01590
010143	*	0.0220	CULLMAN	01210
010150		0.0266	BUTLER	01060
010158	*	0.0121	FRANKLIN	01290
010164	*	0.0188	TALLADEGA	01600
013027		0.0153	BALDWIN	01010
013032		0.0061	ETOWAH	01270
014006		0.0061	ETOWAH	01270
030067		0.0288	LAPAZ	03055
040014	*	0.0161	WHITE	04720
040019		0.0253	ST. FRANCIS	04610
040039	*	0.0055	GREENE	04270
040047		0.0037	RANDOLPH	04600
040067		0.0046	COLUMBIA	04130
040071	*	0.0070	JEFFERSON	04340
040076	*	0.0981	HOT SPRING	04290
040081		0.0398	PIKE	04540
042007		0.0070	JEFFERSON	04340
042011		0.0161	WHITE	04720
050002	*	0.0055	ALAMEDA	05000
050007		0.0230	SAN MATEO	05510

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
050009	*	0.0177	NAPA	05380
050013	*	0.0177	NAPA	05380
050014	*	0.0212	AMADOR	05020
050042	*	0.0254	TEHAMA	05620
050043	*	0.0055	ALAMEDA	05000
050069	*	0.0013	ORANGE	05400
050070		0.0230	SAN MATEO	05510
050073	*	0.0295	SOLANO	05580
050075	*	0.0055	ALAMEDA	05000
050089	*	0.0011	SAN BERNARDINO	05460
050099	*	0.0011	SAN BERNARDINO	05460
050101	*	0.0295	SOLANO	05580
050113		0.0230	SAN MATEO	05510
050129	*	0.0011	SAN BERNARDINO	05460
050133		0.0231	YUBA	05680
050140	*	0.0011	SAN BERNARDINO	05460
050150	*	0.0445	NEVADA	05390
050168	*	0.0013	ORANGE	05400
050173	*	0.0013	ORANGE	05400
050193	*	0.0013	ORANGE	05400
050195	*	0.0055	ALAMEDA	05000
050197	*	0.0230	SAN MATEO	05510
050211	*	0.0055	ALAMEDA	05000
050224	*	0.0013	ORANGE	05400
050226	*	0.0013	ORANGE	05400
050230	*	0.0013	ORANGE	05400
050245	*	0.0011	SAN BERNARDINO	05460
050264	*	0.0055	ALAMEDA	05000
050272	*	0.0011	SAN BERNARDINO	05460

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
050279	*	0.0011	SAN BERNARDINO	05460
050283	*	0.0055	ALAMEDA	05000
050289		0.0230	SAN MATEO	05510
050298		0.0011	SAN BERNARDINO	05460
050300	*	0.0011	SAN BERNARDINO	05460
050305	*	0.0055	ALAMEDA	05000
050320	*	0.0055	ALAMEDA	05000
050325		0.0047	TUOLUMNE	05650
050327	*	0.0011	SAN BERNARDINO	05460
050335	*	0.0047	TUOLUMNE	05650
050348	*	0.0013	ORANGE	05400
050366	*	0.0141	CALAVERAS	05040
050367	*	0.0295	SOLANO	05580
050426	*	0.0013	ORANGE	05400
050444		0.0287	MERCED	05340
050488	*	0.0055	ALAMEDA	05000
050512	*	0.0055	ALAMEDA	05000
050517	*	0.0011	SAN BERNARDINO	05460
050526	*	0.0013	ORANGE	05400
050528	*	0.0287	MERCED	05340
050541	*	0.0230	SAN MATEO	05510
050543	*	0.0013	ORANGE	05400
050548	*	0.0013	ORANGE	05400
050551	*	0.0013	ORANGE	05400
050567	*	0.0013	ORANGE	05400
050570	*	0.0013	ORANGE	05400
050580	*	0.0013	ORANGE	05400
050586	*	0.0011	SAN BERNARDINO	05460
050589	*	0.0013	ORANGE	05400

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
050603	*	0.0013	ORANGE	05400
050609	*	0.0013	ORANGE	05400
050618	*	0.0011	SAN BERNARDINO	05460
050667	*	0.0177	NAPA	05380
050678	*	0.0013	ORANGE	05400
050680	*	0.0295	SOLANO	05580
050693	*	0.0013	ORANGE	05400
050744	*	0.0013	ORANGE	05400
050745	*	0.0013	ORANGE	05400
050746	*	0.0013	ORANGE	05400
050747	*	0.0013	ORANGE	05400
050754		0.0230	SAN MATEO	05510
050758	*	0.0011	SAN BERNARDINO	05460
052034		0.0055	ALAMEDA	05000
052035		0.0013	ORANGE	05400
052037		0.0011	SAN BERNARDINO	05460
052039		0.0013	ORANGE	05400
052040		0.0011	SAN BERNARDINO	05460
052053		0.0013	ORANGE	05400
053034		0.0013	ORANGE	05400
053037		0.0011	SAN BERNARDINO	05460
053301		0.0055	ALAMEDA	05000
053304		0.0013	ORANGE	05400
053306		0.0013	ORANGE	05400
053308		0.0013	ORANGE	05400
054074		0.0295	SOLANO	05580
054093		0.0011	SAN BERNARDINO	05460
054110		0.0055	ALAMEDA	05000
054111		0.0011	SAN	05460

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
			BERNARDINO	
054122		0.0177	NAPA	05380
054135		0.0013	ORANGE	05400
054141		0.0295	SOLANO	05580
054146		0.0055	ALAMEDA	05000
060001	*	0.0096	WELD	06610
060003	*	0.0101	BOULDER	06060
060027	*	0.0101	BOULDER	06060
060103	*	0.0101	BOULDER	06060
060116	*	0.0101	BOULDER	06060
060121		0.0096	WELD	06610
063033		0.0096	WELD	06610
064007		0.0101	BOULDER	06060
080001		0.0044	NEW CASTLE	08010
080003		0.0044	NEW CASTLE	08010
082000		0.0044	NEW CASTLE	08010
083300		0.0044	NEW CASTLE	08010
084001		0.0044	NEW CASTLE	08010
084002		0.0044	NEW CASTLE	08010
084003		0.0044	NEW CASTLE	08010
090001		0.0033	THE DISTRICT	09000
090003		0.0033	THE DISTRICT	09000
090004		0.0033	THE DISTRICT	09000
090005		0.0033	THE DISTRICT	09000
090006		0.0033	THE DISTRICT	09000
090008		0.0033	THE DISTRICT	09000
090011		0.0033	THE DISTRICT	09000
092002		0.0033	THE DISTRICT	09000
092003		0.0033	THE DISTRICT	09000
093025		0.0033	THE DISTRICT	09000
093300		0.0033	THE DISTRICT	09000
094001		0.0033	THE DISTRICT	09000
094004		0.0033	THE DISTRICT	09000
100014	*	0.0058	VOLUSIA	10630

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
100017	*	0.0058	VOLUSIA	10630
100023	*	0.0031	CITRUS	10080
100045	*	0.0058	VOLUSIA	10630
100047	*	0.0028	CHARLOTTE	10070
100068	*	0.0058	VOLUSIA	10630
100072	*	0.0058	VOLUSIA	10630
100077	*	0.0028	CHARLOTTE	10070
100081	*	0.0022	WALTON	10650
100118	*	0.0250	FLAGLER	10170
100139	*	0.0006	LEVY	10370
100232	*	0.0068	PUTNAM	10530
100236	*	0.0028	CHARLOTTE	10070
100249	*	0.0031	CITRUS	10080
100252	*	0.0258	OKEECHOBEE	10460
100290	*	0.0338	SUMTER	10590
100292	*	0.0022	WALTON	10650
110023	*	0.0247	GORDON	11500
110029	*	0.0002	HALL	11550
110040	*	0.1219	JACKSON	11610
110041	*	0.0704	HABERSHAM	11540
110100		0.0821	JEFFERSON	11620
110101		0.0070	COOK	11311
110142		0.0192	EVANS	11441
110146	*	0.0364	CAMDEN	11170
110150	*	0.0209	BALDWIN	11030
110187	*	0.0727	LUMPKIN	11701
110189	*	0.0046	FANNIN	11450
110190	*	0.0106	MACON	11710
110205		0.0466	GILMER	11471
114018		0.0209	BALDWIN	11030
130003	*	0.0165	NEZ PERCE	13340
130024		0.0687	BONNER	13080
130049	*	0.0365	KOOTENAI	13270
130066		0.0365	KOOTENAI	13270

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
130067	*	0.1031	BINGHAM	13050
132001		0.0365	KOOTENAI	13270
134010		0.1031	BINGHAM	13050
140001		0.0321	FULTON	14370
140026		0.0302	LA SALLE	14580
140043	*	0.0036	WHITESIDE	14988
140058	*	0.0119	MORGAN	14770
140110	*	0.0302	LA SALLE	14580
140116	*	0.0014	MC HENRY	14640
140160	*	0.0332	STEPHENSON	14970
140161	*	0.0178	LIVINGSTON	14610
140167	*	0.0769	IROQUOIS	14460
140176	*	0.0014	MC HENRY	14640
140234		0.0302	LA SALLE	14580
150022		0.0251	MONTGOMERY	15530
150030	*	0.0242	HENRY	15320
150072		0.0093	CASS	15080
150076	*	0.0296	MARSHALL	15490
150088	*	0.0038	MADISON	15470
150091	*	0.0095	HUNTINGTON	15340
150102	*	0.0179	STARKE	15740
150113	*	0.0038	MADISON	15470
150133	*	0.0211	KOSCIUSKO	15420
150146	*	0.0087	NOBLE	15560
153040		0.0296	MARSHALL	15490
154014		0.0211	KOSCIUSKO	15420
154035		0.0093	CASS	15080
154047		0.0296	MARSHALL	15490
160013		0.0192	MUSCATINE	16690
160030		0.0013	STORY	16840
160032		0.0349	JASPER	16490
160080	*	0.0023	CLINTON	16220
170137	*	0.0421	DOUGLAS	17220
170150		0.0143	COWLEY	17170

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
180012	*	0.0094	HARDIN	18460
180017	*	0.0090	BARREN	18040
180049	*	0.0312	MADISON	18750
180064		0.0201	MONTGOMERY	18860
180066		0.0523	LOGAN	18700
180070		0.0112	GRAYSON	18420
180079		0.0166	HARRISON	18480
183028		0.0094	HARDIN	18460
184012		0.0094	HARDIN	18460
190003	*	0.0070	IBERIA	19220
190015	*	0.0237	TANGIPAHOA	19520
190017	*	0.0156	ST. LANDRY	19480
190034		0.0156	VERMILION	19560
190044		0.0215	ACADIA	19000
190050		0.0056	BEAUREGARD	19050
190053		0.0107	JEFFRSON DAVIS	19260
190054		0.0070	IBERIA	19220
190078		0.0156	ST. LANDRY	19480
190086	*	0.0054	LINCOLN	19300
190088		0.0278	WEBSTER	19590
190099		0.0108	AVOYELLES	19040
190106	*	0.0082	ALLEN	19010
190116		0.0074	MOREHOUSE	19330
190133		0.0082	ALLEN	19010
190140		0.0030	FRANKLIN	19200
190144	*	0.0278	WEBSTER	19590
190145		0.0051	LA SALLE	19290
190184		0.0075	CALDWELL	19100
190190	*	0.0075	CALDWELL	19100
190191		0.0156	ST. LANDRY	19480
190246		0.0075	CALDWELL	19100
190257	*	0.0054	LINCOLN	19300
192022		0.0054	LINCOLN	19300
192026		0.0278	WEBSTER	19590

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
192034		0.0156	ST. LANDRY	19480
192036		0.0237	TANGIPAHOA	19520
192040		0.0237	TANGIPAHOA	19520
192050		0.0215	ACADIA	19000
193036		0.0156	ST. LANDRY	19480
193044		0.0237	TANGIPAHOA	19520
193047		0.0156	VERMILION	19560
193049		0.0156	VERMILION	19560
193055		0.0075	CALDWELL	19100
193058		0.0074	MOREHOUSE	19330
193063		0.0237	TANGIPAHOA	19520
193067		0.0107	JEFFRSON DAVIS	19260
193068		0.0237	TANGIPAHOA	19520
193069		0.0074	MOREHOUSE	19330
193073		0.0156	ST. LANDRY	19480
193079		0.0237	TANGIPAHOA	19520
193081		0.0215	ACADIA	19000
193088		0.0215	ACADIA	19000
193091		0.0070	IBERIA	19220
194047		0.0278	WEBSTER	19590
194065		0.0054	LINCOLN	19300
194075		0.0107	JEFFRSON DAVIS	19260
194077		0.0054	LINCOLN	19300
194081		0.0056	BEAUREGARD	19050
194082		0.0107	JEFFRSON DAVIS	19260
194083		0.0074	MOREHOUSE	19330
194085		0.0215	ACADIA	19000
194087		0.0054	LINCOLN	19300
194091		0.0237	TANGIPAHOA	19520
194092		0.0030	FRANKLIN	19200
194095		0.0156	ST. LANDRY	19480
194097		0.0156	ST. LANDRY	19480
200024	*	0.0131	ANDROSCOGGIN	20000
200032		0.0367	OXFORD	20080

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
200034	*	0.0131	ANDROSCOGGIN	20000
200050	*	0.0169	HANCOCK	20040
210001		0.0096	WASHINGTON	21210
210023		0.0035	ANNE ARUNDEL	21010
210028		0.0383	ST. MARYS	21180
210043		0.0035	ANNE ARUNDEL	21010
210061		0.0188	WORCESTER	21230
212002		0.0096	WASHINGTON	21210
214001		0.0035	ANNE ARUNDEL	21010
214003		0.0096	WASHINGTON	21210
214015		0.0188	WORCESTER	21230
220001	*	0.0072	WORCESTER	22170
220002		0.0438	MIDDLESEX	22090
220010	*	0.0307	ESSEX	22040
220011		0.0438	MIDDLESEX	22090
220019	*	0.0072	WORCESTER	22170
220025		0.0072	WORCESTER	22170
220029	*	0.0307	ESSEX	22040
220033	*	0.0307	ESSEX	22040
220035	*	0.0307	ESSEX	22040
220049		0.0438	MIDDLESEX	22090
220058	*	0.0072	WORCESTER	22170
220062	*	0.0072	WORCESTER	22170
220063		0.0438	MIDDLESEX	22090
220070		0.0438	MIDDLESEX	22090
220080	*	0.0307	ESSEX	22040
220082		0.0438	MIDDLESEX	22090
220084		0.0438	MIDDLESEX	22090
220090	*	0.0072	WORCESTER	22170
220095	*	0.0072	WORCESTER	22170
220098		0.0438	MIDDLESEX	22090
220101		0.0438	MIDDLESEX	22090
220105		0.0438	MIDDLESEX	22090
220163	*	0.0072	WORCESTER	22170

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
220171		0.0438	MIDDLESEX	22090
220174	*	0.0307	ESSEX	22040
220175		0.0438	MIDDLESEX	22090
220176	*	0.0072	WORCESTER	22170
222000		0.0438	MIDDLESEX	22090
222003		0.0438	MIDDLESEX	22090
222024		0.0438	MIDDLESEX	22090
222026		0.0307	ESSEX	22040
222044		0.0307	ESSEX	22040
222047		0.0307	ESSEX	22040
222048		0.0072	WORCESTER	22170
223026		0.0438	MIDDLESEX	22090
223028		0.0307	ESSEX	22040
223029		0.0072	WORCESTER	22170
223033		0.0072	WORCESTER	22170
224007		0.0438	MIDDLESEX	22090
224026		0.0072	WORCESTER	22170
224032		0.0072	WORCESTER	22170
224033		0.0307	ESSEX	22040
224038		0.0438	MIDDLESEX	22090
224039		0.0307	ESSEX	22040
230002	*	0.0043	WAYNE	23810
230003	*	0.0317	OTTAWA	23690
230005		0.0489	LENAWEE	23450
230013	*	0.0023	OAKLAND	23620
230015		0.0314	ST. JOSEPH	23740
230019	*	0.0023	OAKLAND	23620
230020	*	0.0043	WAYNE	23810
230021	*	0.0159	BERRIEN	23100
230022	*	0.0214	BRANCH	23110
230024	*	0.0043	WAYNE	23810
230029	*	0.0023	OAKLAND	23620
230035	*	0.0144	MONTCALM	23580
230037	*	0.0235	HILLSDALE	23290

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
230041		0.0052	BAY	23080
230047	*	0.0020	MACOMB	23490
230053	*	0.0043	WAYNE	23810
230071	*	0.0023	OAKLAND	23620
230072	*	0.0317	OTTAWA	23690
230075		0.0066	CALHOUN	23120
230078	*	0.0159	BERRIEN	23100
230089	*	0.0043	WAYNE	23810
230092		0.0205	JACKSON	23370
230093		0.0088	MECOSTA	23530
230096	*	0.0314	ST. JOSEPH	23740
230099	*	0.0075	MONROE	23570
230104	*	0.0043	WAYNE	23810
230121	*	0.0923	SHIAWASSEE	23770
230130	*	0.0023	OAKLAND	23620
230135	*	0.0043	WAYNE	23810
230142	*	0.0043	WAYNE	23810
230146	*	0.0043	WAYNE	23810
230151	*	0.0023	OAKLAND	23620
230165	*	0.0043	WAYNE	23810
230174	*	0.0317	OTTAWA	23690
230176	*	0.0043	WAYNE	23810
230195	*	0.0020	MACOMB	23490
230204	*	0.0020	MACOMB	23490
230207	*	0.0023	OAKLAND	23620
230208	*	0.0144	MONTCALM	23580
230217		0.0066	CALHOUN	23120
230222	*	0.0098	MIDLAND	23550
230227	*	0.0020	MACOMB	23490
230244	*	0.0043	WAYNE	23810
230254	*	0.0023	OAKLAND	23620
230257	*	0.0020	MACOMB	23490
230264	*	0.0020	MACOMB	23490
230269	*	0.0023	OAKLAND	23620

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
230270	*	0.0043	WAYNE	23810
230273	*	0.0043	WAYNE	23810
230277	*	0.0023	OAKLAND	23620
230297	*	0.0043	WAYNE	23810
230301	*	0.0023	OAKLAND	23620
230302	*	0.0023	OAKLAND	23620
232019		0.0043	WAYNE	23810
232020		0.0052	BAY	23080
232023		0.0020	MACOMB	23490
232025		0.0159	BERRIEN	23100
232027		0.0043	WAYNE	23810
232028		0.0066	CALHOUN	23120
232030		0.0023	OAKLAND	23620
232031		0.0043	WAYNE	23810
232032		0.0043	WAYNE	23810
232036		0.0205	JACKSON	23370
232038		0.0043	WAYNE	23810
233025		0.0066	CALHOUN	23120
233027		0.0043	WAYNE	23810
233028		0.0023	OAKLAND	23620
233300		0.0043	WAYNE	23810
234011		0.0023	OAKLAND	23620
234021		0.0020	MACOMB	23490
234023		0.0023	OAKLAND	23620
234028		0.0043	WAYNE	23810
234034		0.0043	WAYNE	23810
234035		0.0043	WAYNE	23810
234038		0.0043	WAYNE	23810
234039		0.0020	MACOMB	23490
240018		0.0922	GOODHUE	24240
240044		0.0732	WINONA	24840
240064		0.0227	ITASCA	24300
240069	*	0.0312	STEELE	24730
240071	*	0.0404	RICE	24650

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
240101		0.0146	BECKER	24020
240117		0.0614	MOWER	24490
240211		0.1038	PINE	24570
250023	*	0.0726	PEARL RIVER	25540
250040	*	0.0195	JACKSON	25290
250117	*	0.0726	PEARL RIVER	25540
250128		0.0445	PANOLA	25530
250162		0.0025	HANCOCK	25220
252011		0.0445	PANOLA	25530
260059		0.0044	LACLEDE	26520
260064		0.0038	AUDRAIN	26030
260097		0.0358	JOHNSON	26500
260116	*	0.0094	ST. FRANCOIS	26930
260160		0.0144	STODDARD	26985
260163		0.0094	ST. FRANCOIS	26930
264005		0.0094	ST. FRANCOIS	26930
280077	*	0.0084	DODGE	28260
290002	*	0.0148	LYON	29090
300011	*	0.0049	HILLSBOROUGH	30050
300012	*	0.0049	HILLSBOROUGH	30050
300017	*	0.0075	ROCKINGHAM	30070
300020	*	0.0049	HILLSBOROUGH	30050
300023	*	0.0075	ROCKINGHAM	30070
300029	*	0.0075	ROCKINGHAM	30070
300034	*	0.0049	HILLSBOROUGH	30050
303026		0.0075	ROCKINGHAM	30070
304001		0.0075	ROCKINGHAM	30070
310002	*	0.0315	ESSEX	31200
310009	*	0.0315	ESSEX	31200
310015	*	0.0199	MORRIS	31300
310017	*	0.0199	MORRIS	31300
310038	*	0.0239	MIDDLESEX	31270
310039	*	0.0239	MIDDLESEX	31270
310050	*	0.0199	MORRIS	31300

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
310054	*	0.0315	ESSEX	31200
310070	*	0.0239	MIDDLESEX	31270
310076	*	0.0315	ESSEX	31200
310083	*	0.0315	ESSEX	31200
310096	*	0.0315	ESSEX	31200
310108	*	0.0239	MIDDLESEX	31270
310119	*	0.0315	ESSEX	31200
312018		0.0239	MIDDLESEX	31270
312020		0.0199	MORRIS	31300
313025		0.0315	ESSEX	31200
313300		0.0239	MIDDLESEX	31270
314010		0.0315	ESSEX	31200
314011		0.0239	MIDDLESEX	31270
314016		0.0199	MORRIS	31300
314020		0.0315	ESSEX	31200
320003	*	0.0480	SAN MIGUEL	32230
320011		0.0337	RIO ARRIBA	32190
323025		0.0480	SAN MIGUEL	32230
330004	*	0.0916	ULSTER	33740
330008	*	0.0085	WYOMING	33900
330010		0.0079	MONTGOMERY	33380
330027	*	0.0207	NASSAU	33400
330033		0.0233	CHENANGO	33080
330047		0.0079	MONTGOMERY	33380
330073	*	0.0103	GENESEE	33290
330094	*	0.0579	COLUMBIA	33200
330103		0.0153	CATTARAUGUS	33040
330106	*	0.0207	NASSAU	33400
330126	*	0.0491	ORANGE	33540
330132		0.0153	CATTARAUGUS	33040
330135		0.0491	ORANGE	33540
330144		0.0056	STEUBEN	33690
330151		0.0056	STEUBEN	33690
330167	*	0.0207	NASSAU	33400

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
330175		0.0273	CORTLAND	33210
330181	*	0.0207	NASSAU	33400
330182	*	0.0207	NASSAU	33400
330198	*	0.0207	NASSAU	33400
330205		0.0491	ORANGE	33540
330222		0.0016	SARATOGA	33640
330224	*	0.0916	ULSTER	33740
330225	*	0.0207	NASSAU	33400
330235	*	0.0316	CAYUGA	33050
330259	*	0.0207	NASSAU	33400
330264		0.0491	ORANGE	33540
330276		0.0043	FULTON	33280
330277	*	0.0056	STEUBEN	33690
330331	*	0.0207	NASSAU	33400
330332	*	0.0207	NASSAU	33400
330372	*	0.0207	NASSAU	33400
330386	*	0.0853	SULLIVAN	33710
334017		0.0491	ORANGE	33540
334049		0.0016	SARATOGA	33640
334061		0.0491	ORANGE	33540
340020		0.0163	LEE	34520
340021	*	0.0143	CLEVELAND	34220
340024		0.0143	SAMPSON	34810
340027	*	0.0164	LENOIR	34530
340037	*	0.0143	CLEVELAND	34220
340038		0.0329	BEAUFORT	34060
340039	*	0.0090	IREDELL	34480
340068	*	0.0111	COLUMBUS	34230
340070		0.0289	ALAMANCE	34000
340071	*	0.0260	HARNETT	34420
340085	*	0.0259	DAVIDSON	34280
340096	*	0.0259	DAVIDSON	34280
340126	*	0.0130	WILSON	34970
340129	*	0.0090	IREDELL	34480

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
340133		0.0260	MARTIN	34580
340144	*	0.0090	IREDELL	34480
340145	*	0.0306	LINCOLN	34540
340151		0.0084	HALIFAX	34410
360002		0.0092	ASHLAND	36020
360010	*	0.0012	TUSCARAWAS	36800
360013	*	0.0135	SHELBY	36760
360025	*	0.0065	ERIE	36220
360036	*	0.0146	WAYNE	36860
360040		0.0445	KNOX	36430
360044		0.0127	DARKE	36190
360055	*	0.0011	TRUMBULL	36790
360065	*	0.0053	HURON	36400
360070		0.0005	STARK	36770
360071		0.0071	VAN WERT	36820
360084		0.0005	STARK	36770
360086	*	0.0086	CLARK	36110
360096		0.0011	COLUMBIANA	36140
360107		0.0163	SANDUSKY	36730
360125	*	0.0099	ASHTABULA	36030
360131		0.0005	STARK	36770
360151		0.0005	STARK	36770
360156		0.0163	SANDUSKY	36730
360161		0.0011	TRUMBULL	36790
360175	*	0.0192	CLINTON	36130
360185		0.0011	COLUMBIANA	36140
360245	*	0.0099	ASHTABULA	36030
360355		0.0086	CLARK	36110
360356		0.0163	SANDUSKY	36730
362016		0.0005	STARK	36770
362032		0.0005	STARK	36770
363026		0.0011	TRUMBULL	36790
364031		0.0005	STARK	36770
364040		0.0086	CLARK	36110

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
364043		0.0071	VAN WERT	36820
370014	*	0.0167	BRYAN	37060
370015	*	0.0388	MAYES	37480
370023		0.0071	STEPHENS	37680
370065		0.0102	CRAIG	37170
370149	*	0.0240	POTTAWATOMIE	37620
370156		0.0096	GARVIN	37240
370169		0.0173	MCINTOSH	37450
370214		0.0096	GARVIN	37240
372019		0.0240	POTTAWATOMIE	37620
380022		0.0126	LINN	38210
390008		0.0011	LAWRENCE	39450
390016	*	0.0011	LAWRENCE	39450
390030	*	0.0147	SCHUYLKILL	39650
390031	*	0.0147	SCHUYLKILL	39650
390039		0.0037	SOMERSET	39680
390044	*	0.0250	BERKS	39110
390052		0.0018	CLEARFIELD	39230
390056		0.0022	HUNTINGDON	39380
390065	*	0.0591	ADAMS	39000
390066	*	0.0269	LEBANON	39460
390086	*	0.0018	CLEARFIELD	39230
390096	*	0.0250	BERKS	39110
390110	*	0.0006	CAMBRIA	39160
390112		0.0037	SOMERSET	39680
390117		0.0008	BEDFORD	39100
390130	*	0.0006	CAMBRIA	39160
390138	*	0.0204	FRANKLIN	39350
390150		0.0005	GREENE	39370
390151	*	0.0204	FRANKLIN	39350
390162	*	0.0217	NORTHAMPTON	39590
390173		0.0037	INDIANA	39390
390183	*	0.0147	SCHUYLKILL	39650
390201		0.0945	MONROE	39550

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
390313	*	0.0147	SCHUYLKILL	39650
390316	*	0.0250	BERKS	39110
392030		0.0591	ADAMS	39000
392031		0.0006	CAMBRIA	39160
392034		0.0217	NORTHAMPTON	39590
393026		0.0250	BERKS	39110
393050		0.0217	NORTHAMPTON	39590
394014		0.0250	BERKS	39110
394020		0.0269	LEBANON	39460
394052		0.0250	BERKS	39110
420002		0.0001	YORK	42450
420005		0.0013	DILLON	42160
420007		0.0027	SPARTANBURG	42410
420019		0.0170	CHESTER	42110
420020	*	0.0008	GEORGETOWN	42210
420027	*	0.0157	ANDERSON	42030
420030	*	0.0153	COLLETON	42140
420036	*	0.0075	LANCASTER	42280
420039	*	0.0110	UNION	42430
420043		0.0175	CHEROKEE	42100
420053		0.0111	NEWBERRY	42350
420054		0.0002	MARLBORO	42340
420055		0.0032	MARION	42330
420062		0.0125	CHESTERFIELD	42120
420068	*	0.0072	ORANGEBURG	42370
420069	*	0.0006	CLARENDON	42130
420070	*	0.0051	SUMTER	42420
420082		0.0002	AIKEN	42010
420083		0.0027	SPARTANBURG	42410
420098		0.0008	GEORGETOWN	42210
422004		0.0027	SPARTANBURG	42410
423028		0.0001	YORK	42450
423029		0.0157	ANDERSON	42030
424011		0.0157	ANDERSON	42030

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
430048		0.0353	LAWRENCE	43400
430094		0.0353	LAWRENCE	43400
440007		0.0179	COFFEE	44150
440008		0.0249	HENDERSON	44380
440012		0.0009	SULLIVAN	44810
440016		0.0080	CARROLL	44080
440017		0.0009	SULLIVAN	44810
440025	*	0.0009	GREENE	44290
440035	*	0.0300	MONTGOMERY	44620
440047		0.0188	GIBSON	44260
440050		0.0009	GREENE	44290
440051		0.0045	MC NAIRY	44540
440060		0.0188	GIBSON	44260
440063		0.0033	WASHINGTON	44890
440070		0.0060	DECATUR	44190
440105		0.0033	WASHINGTON	44890
440109		0.0039	HARDIN	44350
440115		0.0188	GIBSON	44260
440137		0.0605	BEDFORD	44010
440144	*	0.0179	COFFEE	44150
440148		0.0242	DE KALB	44200
440174	*	0.0235	HAYWOOD	44370
440176		0.0009	SULLIVAN	44810
440181		0.0306	HARDEMAN	44340
440182		0.0080	CARROLL	44080
440184		0.0033	WASHINGTON	44890
440185	*	0.0254	BRADLEY	44050
442016		0.0009	SULLIVAN	44810
443027		0.0009	SULLIVAN	44810
444006		0.0033	WASHINGTON	44890
444008		0.0306	HARDEMAN	44340
450032	*	0.0216	HARRISON	45620
450039	*	0.0054	TARRANT	45910
450052	*	0.0333	BOSQUE	45160

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
450064	*	0.0054	TARRANT	45910
450087	*	0.0054	TARRANT	45910
450090		0.0711	COOKE	45340
450099	*	0.0085	GRAY	45563
450135	*	0.0054	TARRANT	45910
450137	*	0.0054	TARRANT	45910
450144	*	0.0447	ANDREWS	45010
450163		0.0116	KLEBERG	45743
450192		0.0316	HILL	45651
450194		0.0053	CHEROKEE	45281
450210		0.0128	PANOLA	45842
450224	*	0.0056	WOOD	45974
450236		0.0426	HOPKINS	45654
450270		0.0316	HILL	45651
450283	*	0.0422	VAN ZANDT	45947
450347	*	0.0396	WALKER	45949
450348	*	0.0094	FALLS	45500
450370	*	0.0251	COLORADO	45312
450389	*	0.0413	HENDERSON	45640
450395		0.0472	POLK	45850
450419	*	0.0054	TARRANT	45910
450438	*	0.0251	COLORADO	45312
450451		0.0524	SOMERVELL	45893
450460		0.0056	TYLER	45942
450497		0.0516	MONTAGUE	45800
450539		0.0139	HALE	45582
450547	*	0.0056	WOOD	45974
450563	*	0.0054	TARRANT	45910
450565	*	0.0509	PALO PINTO	45841
450573		0.0133	JASPER	45690
450596	*	0.0727	HOOD	45653
450597		0.0004	DE WITT	45420
450615		0.0033	CASS	45260
450639	*	0.0054	TARRANT	45910

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
450641		0.0516	MONTAGUE	45800
450672	*	0.0054	TARRANT	45910
450675	*	0.0054	TARRANT	45910
450677	*	0.0054	TARRANT	45910
450698		0.0264	LAMB	45751
450747	*	0.0031	ANDERSON	45000
450755		0.0575	HOCKLEY	45652
450770	*	0.0219	MILAM	45795
450779	*	0.0054	TARRANT	45910
450813		0.0031	ANDERSON	45000
450872	*	0.0054	TARRANT	45910
450880	*	0.0054	TARRANT	45910
450886	*	0.0054	TARRANT	45910
450888		0.0054	TARRANT	45910
452018		0.0054	TARRANT	45910
452019		0.0054	TARRANT	45910
452028		0.0054	TARRANT	45910
452088		0.0054	TARRANT	45910
452099		0.0054	TARRANT	45910
452110		0.0054	TARRANT	45910
453040		0.0054	TARRANT	45910
453041		0.0054	TARRANT	45910
453042		0.0054	TARRANT	45910
453089		0.0031	ANDERSON	45000
453094		0.0054	TARRANT	45910
453300		0.0054	TARRANT	45910
453303		0.0054	TARRANT	45910
454009		0.0053	CHEROKEE	45281
454012		0.0054	TARRANT	45910
454051		0.0054	TARRANT	45910
454052		0.0054	TARRANT	45910
454061		0.0054	TARRANT	45910
454072		0.0054	TARRANT	45910
454086		0.0054	TARRANT	45910

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
454101		0.0139	HALE	45582
460001		0.0001	UTAH	46240
460013		0.0001	UTAH	46240
460017		0.0229	BOX ELDER	46010
460023		0.0001	UTAH	46240
460039	*	0.0229	BOX ELDER	46010
460043		0.0001	UTAH	46240
460052		0.0001	UTAH	46240
462005		0.0001	UTAH	46240
490002		0.0003	RUSSELL	49830
490019	*	0.1048	CULPEPER	49230
490038		0.0003	SMYTH	49860
490084		0.0236	ESSEX	49280
490105		0.0003	SMYTH	49860
490110		0.0176	MONTGOMERY	49600
493026		0.0218	AUGUSTA	49070
494029		0.0003	SMYTH	49860
500003	*	0.0270	SKAGIT	50280
500007	*	0.0270	SKAGIT	50280
500019		0.0166	LEWIS	50200
500024		0.0064	THURSTON	50330
500039	*	0.0182	KITSAP	50170
500041	*	0.0055	COWLITZ	50070
500139		0.0064	THURSTON	50330
500143		0.0064	THURSTON	50330
510012		0.0110	MASON	51260
510018	*	0.0106	JACKSON	51170
510047	*	0.0233	MARION	51240
520009		0.0027	OUTAGAMIE	52430
520028	*	0.0413	GREEN	52220
520035		0.0112	SHEBOYGAN	52580
520044		0.0112	SHEBOYGAN	52580
520045		0.0022	WINNEBAGO	52690
520048		0.0022	WINNEBAGO	52690

ADDENDUM L.—FINAL CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
520057		0.0268	SAUK	52550
520071	*	0.0267	JEFFERSON	52270
520076	*	0.0219	DODGE	52130
520088		0.0084	FOND DU LAC	52190
520095	*	0.0268	SAUK	52550
520102		0.0599	WALWORTH	52630
520116	*	0.0267	JEFFERSON	52270
520160		0.0027	OUTAGAMIE	52430
520198		0.0022	WINNEBAGO	52690
523302		0.0022	WINNEBAGO	52690
524002		0.0022	WINNEBAGO	52690
524025		0.0084	FOND DU LAC	52190
673035		0.0054	TARRANT	45910

*: Asterisk indicates hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesiganted under section 1886(d)(8)(B) of the Act for CY 2011.

ADDENDUM M.—HCPCS CODES FOR ASSIGNMENT TO COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
90801	Psy dx interview		Q3	0323	0034
90802	Intac psy dx interview		Q3	0323	0034
90804	Psytx office 20-30 min		Q3	0322	0034
90805	Psytx off 20-30 min w/e&m		Q3	0322	0034
90806	Psytx off 45-50 min		Q3	0323	0034
90807	Psytx off 45-50 min w/e&m		Q3	0323	0034
90808	Psytx office 75-80 min		Q3	0323	0034
90809	Psytx off 75-80 w/e&m		Q3	0323	0034
90810	Intac psytx off 20-30 min		Q3	0322	0034
90811	Intac psytx 20-30 w/e&m		Q3	0322	0034
90812	Intac psytx off 45-50 min		Q3	0323	0034
90813	Intac psytx 45-50 min w/e&m		Q3	0323	0034
90814	Intac psytx off 75-80 min		Q3	0323	0034
90815	Intac psytx 75-80 w/e&m		Q3	0323	0034
90845	Psychoanalysis		Q3	0323	0034
90846	Family psytx w/o patient		Q3	0324	0034
90847	Family psytx w/patient		Q3	0324	0034
90849	Multiple family group psytx		Q3	0325	0034
90853	Group psychotherapy		Q3	0325	0034
90857	Intac group psytx		Q3	0325	0034
90862	Medication management	CH	Q3	0605	0034
90865	Narcosynthesis		Q3	0323	0034
90880	Hypnotherapy		Q3	0323	0034
90899	Psychiatric service/therapy		Q3	0322	0034
96101	Psycho testing by psych/phys		Q3	0382	0034
96102	Psycho testing by technician		Q3	0382	0034
96103	Psycho testing admin by comp		Q3	0373	0034
96110	Developmental test lim		Q3	0373	0034
96111	Developmental test extend		Q3	0373	0034
96116	Neurobehavioral status exam		Q3	0382	0034
96118	Neuropsych tst by psych/phys		Q3	0382	0034
96119	Neuropsych testing by tec		Q3	0382	0034
96120	Neuropsych tst admin w/comp		Q3	0382	0034
96150	Assess hlth/behave init		Q3	0432	0034
96151	Assess hlth/behave subseq		Q3	0432	0034
96152	Intervene hlth/behave indiv		Q3	0432	0034
96153	Intervene hlth/behave group		Q3	0432	0034
96154	Interv hlth/behav fam w/pt		Q3	0432	0034

ADDENDUM M.—HCPCS CODES FOR ASSIGNMENT TO COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
M0064	Visit for drug monitoring		Q3	0607	0034
36600	Withdrawal of arterial blood	CH	Q3	0035	0617, 0618, or 8003
71010	Chest x-ray	CH	Q3	0260	0617, 0618, or 8003
71015	Chest x-ray	CH	Q3	0260	0617, 0618, or 8003
71020	Chest x-ray	CH	Q3	0260	0617, 0618, or 8003
92953	Temporary external pacing	CH	Q3	0094	0617, 0618, or 8003
94002	Vent mgmt inpat init day	CH	Q3	0079	0617, 0618, or 8003
94003	Vent mgmt inpat subq day	CH	Q3	0079	0617, 0618, or 8003
94660	Pos airway pressure cpap	CH	Q3	0078	0617, 0618, or 8003
94662	Neg press ventilation cnp	CH	Q3	0079	0617, 0618, or 8003
94762	Measure blood oxygen level	CH	Q3	0097	0617, 0618, or 8003
43752	Nasal/orogastric w/stent	CH	Q3	0272	0617, 0618, or 8003
93619	Electrophysiology evaluation		Q3	0085	8000
93620	Electrophysiology evaluation		Q3	0085	8000
93650	Ablate heart dysrhythm focus		Q3	0085	8000
93651	Ablate heart dysrhythm focus		Q3	0086	8000
93652	Ablate heart dysrhythm focus		Q3	0086	8000
55875	Transperi needle place pros		Q3	0163	8001
77778	Apply interstit radiat compl		Q3	0651	8001
99205	Office/outpatient visit new		Q3	0608	8002
99215	Office/outpatient visit est		Q3	0607	8002
G0379	Direct refer hospital observ		Q3	0604	8002
99284	Emergency dept visit		Q3	0615	8003
99285	Emergency dept visit		Q3	0616	8003
99291	Critical care first hour		Q3	0617	8003
G0384	Lev 5 hosp type B ED visit		Q3	0630	8003
76604	Us exam chest		Q3	0265	8004
76700	Us exam abdom complete		Q3	0266	8004
76705	Echo exam of abdomen		Q3	0266	8004
76770	Us exam abdo back wall comp		Q3	0266	8004
76775	Us exam abdo back wall lim		Q3	0266	8004

ADDENDUM M.—HCPCS CODES FOR ASSIGNMENT TO COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
76776	Us exam k transpl w/doppler		Q3	0266	8004
76831	Echo exam uterus		Q3	0267	8004
76856	Us exam pelvic complete		Q3	0266	8004
76857	Us exam pelvic limited		Q3	0265	8004
76870	Us exam scrotum		Q3	0266	8004
74176	Ct abd & pelvis w/o contrast	NI	Q3	0332	8005
70450	Ct head/brain w/o dye		Q3	0332	8005 or 8006
70480	Ct orbit/ear/fossa w/o dye		Q3	0332	8005 or 8006
70486	Ct maxillofacial w/o dye		Q3	0332	8005 or 8006
70490	Ct soft tissue neck w/o dye		Q3	0332	8005 or 8006
71250	Ct thorax w/o dye		Q3	0332	8005 or 8006
72125	Ct neck spine w/o dye		Q3	0332	8005 or 8006
72128	Ct chest spine w/o dye		Q3	0332	8005 or 8006
72131	Ct lumbar spine w/o dye		Q3	0332	8005 or 8006
72192	Ct pelvis w/o dye		Q3	0332	8005 or 8006
73200	Ct upper extremity w/o dye		Q3	0332	8005 or 8006
73700	Ct lower extremity w/o dye		Q3	0332	8005 or 8006
74150	Ct abdomen w/o dye		Q3	0332	8005 or 8006
74261	Ct colonography dx		Q3	0332	8005 or 8006
70460	Ct head/brain w/dye		Q3	0283	8006
70470	Ct head/brain w/o & w/dye		Q3	0333	8006
70481	Ct orbit/ear/fossa w/dye		Q3	0283	8006
70482	Ct orbit/ear/fossa w/o&w/dye		Q3	0333	8006
70487	Ct maxillofacial w/dye		Q3	0283	8006
70488	Ct maxillofacial w/o & w/dye		Q3	0333	8006
70491	Ct soft tissue neck w/dye		Q3	0283	8006
70492	Ct sft tsue nck w/o & w/dye		Q3	0333	8006
70496	Ct angiography head		Q3	0662	8006
70498	Ct angiography neck		Q3	0662	8006
71260	Ct thorax w/dye		Q3	0283	8006
71270	Ct thorax w/o & w/dye		Q3	0333	8006
71275	Ct angiography chest		Q3	0662	8006
72126	Ct neck spine w/dye		Q3	0283	8006
72127	Ct neck spine w/o & w/dye		Q3	0333	8006
72129	Ct chest spine w/dye		Q3	0283	8006
72130	Ct chest spine w/o & w/dye		Q3	0333	8006
72132	Ct lumbar spine w/dye		Q3	0283	8006
72133	Ct lumbar spine w/o & w/dye		Q3	0333	8006
72191	Ct angiograph pelv w/o&w/dye		Q3	0662	8006
72193	Ct pelvis w/dye		Q3	0283	8006

ADDENDUM M.—HCPCS CODES FOR ASSIGNMENT TO COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
72194	Ct pelvis w/o & w/dye		Q3	0333	8006
73201	Ct upper extremity w/dye		Q3	0283	8006
73202	Ct uppr extremity w/o&w/dye		Q3	0333	8006
73206	Ct angio upr extrm w/o&w/dye		Q3	0662	8006
73701	Ct lower extremity w/dye		Q3	0283	8006
73702	Ct lwr extremity w/o&w/dye		Q3	0333	8006
73706	Ct angio lwr extr w/o&w/dye		Q3	0662	8006
74160	Ct abdomen w/dye		Q3	0283	8006
74170	Ct abdomen w/o & w/dye		Q3	0333	8006
74175	Ct angio abdom w/o & w/dye		Q3	0662	8006
74177	Ct abdomen&pelvis w/contrast	NI	Q3	0283	8006
74178	Ct abd&pelv 1+ section/regns	NI	Q3	0333	8006
74262	Ct colonography dx w/dye		Q3	0283	8006
75635	Ct angio abdominal arteries		Q3	0662	8006
70336	Magnetic image jaw joint		Q3	0336	8007 or 8008
70540	Mri orbit/face/neck w/o dye		Q3	0336	8007 or 8008
70544	Mr angiography head w/o dye		Q3	0336	8007 or 8008
70547	Mr angiography neck w/o dye		Q3	0336	8007 or 8008
70551	Mri brain w/o dye		Q3	0336	8007 or 8008
70554	Fmri brain by tech		Q3	0336	8007 or 8008
71550	Mri chest w/o dye		Q3	0336	8007 or 8008
72141	Mri neck spine w/o dye		Q3	0336	8007 or 8008
72146	Mri chest spine w/o dye		Q3	0336	8007 or 8008
72148	Mri lumbar spine w/o dye		Q3	0336	8007 or 8008
72195	Mri pelvis w/o dye		Q3	0336	8007 or 8008
73218	Mri upper extremity w/o dye		Q3	0336	8007 or 8008
73221	Mri joint upr extrem w/o dye		Q3	0336	8007 or 8008
73718	Mri lower extremity w/o dye		Q3	0336	8007 or 8008
73721	Mri jnt of lwr extre w/o dye		Q3	0336	8007 or 8008
74181	Mri abdomen w/o dye		Q3	0336	8007 or 8008
75557	Cardiac mri for morph		Q3	0336	8007 or 8008
75559	Cardiac mri w/stress img		Q3	0336	8007 or 8008
C8901	MRA w/o cont, abd		Q3	0336	8007 or 8008
C8904	MRI w/o cont, breast, uni		Q3	0336	8007 or 8008
C8907	MRI w/o cont, breast, bi		Q3	0336	8007 or 8008
C8910	MRA w/o cont, chest		Q3	0336	8007 or 8008
C8913	MRA w/o cont, lwr ext		Q3	0336	8007 or 8008
C8919	MRA w/o cont, pelvis		Q3	0336	8007 or 8008
C8932	MRA, w/o dye, spinal canal		Q3	0336	8007 or 8008
C8935	MRA, w/o dye, upper extr		Q3	0336	8007 or 8008

ADDENDUM M.—HCPCS CODES FOR ASSIGNMENT TO COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
70542	Mri orbit/face/neck w/dye		Q3	0284	8008
70543	Mri orbt/fac/nck w/o & w/dye		Q3	0337	8008
70545	Mr angiography head w/dye		Q3	0284	8008
70546	Mr angiograph head w/o&w/dye		Q3	0337	8008
70548	Mr angiography neck w/dye		Q3	0284	8008
70549	Mr angiograph neck w/o&w/dye		Q3	0337	8008
70552	Mri brain w/dye		Q3	0284	8008
70553	Mri brain w/o & w/dye		Q3	0337	8008
71551	Mri chest w/dye		Q3	0284	8008
71552	Mri chest w/o & w/dye		Q3	0337	8008
72142	Mri neck spine w/dye		Q3	0284	8008
72147	Mri chest spine w/dye		Q3	0284	8008
72149	Mri lumbar spine w/dye		Q3	0284	8008
72156	Mri neck spine w/o & w/dye		Q3	0337	8008
72157	Mri chest spine w/o & w/dye		Q3	0337	8008
72158	Mri lumbar spine w/o & w/dye		Q3	0337	8008
72196	Mri pelvis w/dye		Q3	0284	8008
72197	Mri pelvis w/o & w/dye		Q3	0337	8008
73219	Mri upper extremity w/dye		Q3	0284	8008
73220	Mri uppr extremity w/o&w/dye		Q3	0337	8008
73222	Mri joint upr extrem w/dye		Q3	0284	8008
73223	Mri joint upr extr w/o&w/dye		Q3	0337	8008
73719	Mri lower extremity w/dye		Q3	0284	8008
73720	Mri lwr extremity w/o&w/dye		Q3	0337	8008
73722	Mri joint of lwr extr w/dye		Q3	0284	8008
73723	Mri joint lwr extr w/o&w/dye		Q3	0337	8008
74182	Mri abdomen w/dye		Q3	0284	8008
74183	Mri abdomen w/o & w/dye		Q3	0337	8008
75561	Cardiac mri for morph w/dye		Q3	0337	8008
75563	Card mri w/stress img & dye		Q3	0337	8008
C8900	MRA w/cont, abd		Q3	0284	8008
C8902	MRA w/o fol w/cont, abd		Q3	0337	8008
C8903	MRI w/cont, breast, uni		Q3	0284	8008
C8905	MRI w/o fol w/cont, brst, un		Q3	0337	8008
C8906	MRI w/cont, breast, bi		Q3	0284	8008
C8908	MRI w/o fol w/cont, breast,		Q3	0337	8008
C8909	MRA w/cont, chest		Q3	0284	8008
C8911	MRA w/o fol w/cont, chest		Q3	0337	8008
C8912	MRA w/cont, lwr ext		Q3	0284	8008
C8914	MRA w/o fol w/cont, lwr ext		Q3	0337	8008

ADDENDUM M.—HCPCS CODES FOR ASSIGNMENT TO COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
C8918	MRA w/cont, pelvis		Q3	0284	8008
C8920	MRA w/o fol w/cont, pelvis		Q3	0337	8008
C8931	MRA, w/dye, spinal canal		Q3	0284	8008
C8933	MRA, w/o&w/dye, spinal canal		Q3	0337	8008
C8934	MRA, w/dye, upper extremity		Q3	0284	8008
C8936	MRA, w/o&w/dye, upper extr		Q3	0337	8008

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