in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);

• Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);

• Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);

• Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);

• Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the Clean Air Act; and

• Does not provide EPA with the discretionary authority to address disproportionate human health or environmental effects with practical, appropriate, and legally permissible methods under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the State, and EPA notes that it will not impose substantial direct costs on tribal governments or preempt tribal law.

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this action and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by March 7, 2011. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements (see section 307(b)(2)).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Volatile organic compounds.

Dated: September 30, 2011.

Jared Blumenfeld,

Regional Administrator, Region IX.

Part 52, Chapter I, Title 40 of the Code of Federal Regulations is amended as follows:

PART 52—[AMENDED]

■ 1. The authority citation for Part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart F—California

■ 2. Section 52.220 is amended by adding paragraphs (c)(388)(i)(B)(*2*), (*3*), (*4*) and (*5*) to read as follows:

§ 52.220 Identification of plan.

* * * * *

(c) * * *

(388) * * *

(i) * * *

(B) * * *

(*2*) Rule 4103, ''Open Burning,'' amended on April 15, 2010, not effective until June 1, 2010.

(*3*) Table 9–1, Revised Proposed Staff Report and Recommendations on Agricultural Burning, approved on May 20, 2010.

(*4*) San Joaquin Valley Air Pollution Control District, Resolution No. 10–05–22, adopted on May 20, 2010.

(*5*) California Air Resources Board, Resolution 10–24, adopted on May 27, 2010.

* * * * *

[FR Doc. 2011–33660 Filed 1–3–12; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 416, 419, 489, and 495

[CMS–1525–CN]

RIN 0938–AQ26

Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment; Ambulatory Surgical Center Payment; Hospital Value-Based Purchasing Program; Physician Self-Referral; and Patient Notification Requirements in Provider Agreements; Corrections

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

ACTION: Correction of final rule with comment period.

SUMMARY: This document corrects technical errors that appeared in the final rule with comment period published in the **Federal Register** on November 30, 2011, entitled ''Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment; Ambulatory Surgical Center Payment; Hospital Value-Based Purchasing Program; Physician Self-Referral; and Patient Notification Requirements in Provider Agreements.''

DATES: *Effective Date:* This correction is effective January 1, 2012.

FOR FURTHER INFORMATION CONTACT: Marjorie Baldo, (410) 786–0378, Hospital outpatient prospective payment issues. James Poyer, (410) 786–2261, and Donald Howard, (410) 786–6764, Hospital Value-Based Purchasing (VBP) Program Issues.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2011–28612 of November 30, 2011 (76 FR 74122), (hereinafter referred to as the CY 2012 OPPS/ASC final rule with comment period), there were a number of technical errors that are identified and corrected in the Correction of Errors section below. The provisions in this correction document are effective as if they had been included in the CY 2012 OPPS/ASC final rule with comment period (76 FR 74122) appearing in the November 30, 2011 **Federal Register**. Accordingly, the corrections are effective January 1, 2012.

II. Summary of Errors

A. Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Corrections

In the CY 2012 OPPS/ASC final rule with comment period, we finalized a continuation of our policy to exclude line items that were eligible for payment in the claims year but did not meet the Medicare requirements for payment (76 FR 74141). Line items that did not meet the requirements for Medicare payment were rejected or denied during claims processing. It is our longstanding policy to not use line items that were rejected or denied for payment for modeling costs under the OPPS. In reviewing the claims data used to establish the APC median costs for the CY 2012 OPPS/ASC final rule with comment period, we discovered that the trim of unpaid lines was not applied correctly. We have corrected our programming logic in the OPPS data process to apply the line item trim correctly and have recalculated the median costs for each separately paid service using the claims that result from the correctly applied trim. We note that no other changes were made to the programming logic described in the CY 2012 OPPS/ASC final (see 76 FR 74141).

The correct application of the line item based trim has an impact on the APC median costs used to establish the relative payment, which impacts the CY 2012 OPPS/ASC payment rates, copayments, outlier threshold, and impacts. Due to the APC median costs changes, we had to recalculate the budget neutral weight scaler. Using the updated unscaled relative weights, the CY 2012 budget neutrality weight scaler changed from 1.3588 to 1.3585 (see 76 FR 74189). The changes associated with the revised APC median costs and the corrected budget neutrality weight scaler have no further impact on budget neutrality, in particular, those applied to the CY 2012 conversion factor. The correct application of the line item trim changed the data used to model the CY 2012 fixed-dollar outlier threshold. Using the corrected set of claims data, the CY 2012 OPPS/ASC fixed-dollar outlier threshold changed from $1,900 to $2,025 (see 76 FR 74209).

Also, as a result of the recalculated median costs, the APCs now displays violations of the two times rule, which caused the following APC codes to be added: APC 0105 Repair/Revision/Removal of Pacemakers, AICDs and Vascular Access Devices, APC 0263, Level I Miscellaneous Radiology Procedures, and APC 0655, Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacing Electrode.

In addition, the recalculated median costs caused several APCs to no longer display violations of the two times rule, which caused the following APSC codes to be removed: APC 0262 Plain Film of Teeth, APC 0341 Skin Tests and APC 0660 Level II Otorhynolaryngologic Function Tests. We are revising Table 19—Final APC Exceptions to the 2 Times Rule for CY 2012 (76 FR 74227) to reflect these changes.

Furthermore, we made changes to Table 59—Estimated Impact of the Final CY 2012 Changes for the Hospital Outpatient Prospective Payments System (76 FR 74562) and the correlating preamble language (76 FR 74570). Specifically, a hospital that had submitted a claim containing a single line for which no payment was made, is no longer represented in the data, therefore, the number of facilities whose claims are represented in the data declined from 4,161 to 4,160, and the number of hospitals declined from 3,895 to 3,894 (see 76 FR 74558). Because of the trim of lines for which no payment was made from the single procedure bills from the remaining hospitals, the number of hospitals by category, and the impact for the categories have minor changes. In addition to the minor changes to the number of hospitals and the impacts by category of hospital, the estimated increase for all facilities and all hospitals when all changes are accounted for declines from 1.9 percent to 1.8 percent because the CY 2011 threshold models as if it were paying 1.0 percent of total payment for outliers rather than 0.93 percent. Therefore, the estimated total increase in payment based on the technical corrections noted above results in a decline of 0.1 percent.

To view the revised payment rates that result from the changed median costs, we refer readers to the Addenda and supporting files that are posted on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/HORD.* Select ''CMS–1525–FC'' from the list of regulations. All revised Addenda for this correction document are contained in the zipped folder entitled ''2012 OPPS FC Addenda'' at the bottom of the page for CMS–1525–FC. The corrected CY 2012 table of updated offset amounts is posted on the OPPS Web site under ''Annual Policy Files,'' which is found on the left side of the page. The corrected CY 2012 OPPS file of median costs is found under supporting documentation for CMS–1525–FC.

ASC payment rates are based on the OPPS relative payment weights for the majority of services that are provided at ASCs. Therefore, the correct application of the line item based trim also has an impact on the CY 2012 ASC relative payment weights and ASC payment rates. Due to the changes to the OPPS relative payment weights, we had to recalculate the budget neutral ASC weight scaler (see 76 FR 74447 and 74448). Using the updated scaled OPPS relative weights, the CY 2012 budget neutrality ASC weight scaler changed from 0.9466 to 0.9477 (76 FR 74448). The changes associated with the revised OPPS relative payment weights and the corrected budget neutrality CY 2012 ASC weight scaler have no impact on the CY 2012 ASC conversion factor. To view the revised ASC payment rates that result from the revised ASC relative payment weights, see the ASC Addenda that are posted on the CMS Web site at: *http://www.cms.gov/ASCPayment/ASCRN.* Select ''CMS–1525–FC'' from the list of regulations. All revised ASC addenda for this correction document are contained in the zipped folder entitled ''Addenda AA, BB, DD1, DD2, and EE'' at the bottom of the page for CMS–1525–FC.

In addition to the incorrect application of the line item based trim, we failed to recognize that existing HCPCS code C9716 (Creations of thermal anal lesions by radiofrequency energy) was replaced with new CPT code 0288T (Anoscopy, with delivery of thermal energy to the muscle of the anal canal) (for example, for fecal incontinence). For CY 2012, the CPT Editorial Panel created new CPT code 0288T. Before CY 2012, this procedure was described by the Healthcare Common Procedure Coding System (HCPCS) as code C9716. In Addendum B of the CY 2012 OPPS/ASC final rule with comment period, both HCPCS code C9716 and 0288T were assigned to specific APCs. Specifically, HCPCS code C9716 has been assigned to APC 0150 (Level IV Anal/Rectal Procedures) and CPT code 0288T was mistakenly assigned to APC 0148 (Level I Anal/Rectal Procedures). Because HCPCS code C9716 and CPT code 0288T describe the same procedure, CMS is deleting HCPCS code C9716 on December 31, 2011, since it will be replaced with CPT code 0288T effective January 1, 2012. In addition, the APC assignment of CPT code 0288T will be corrected from APC 0148 to APC 0150 effective January 1, 2012. Since 0288T replaces C9716, it should have been assigned to the same APC that C9716 was assigned, APC 150. In addition, we neglected to reflect the inclusion of new HCPCS code G0451 (Development testing, with interpretation and report, per standardized instrument form) in

the mental health composite (APC 0034) and mistakenly assigned it status indicator ''S''. We have corrected this error and assigned status indicator ''Q3'' to HCPCS code G0451. These corrections are included in the revised OPPS and ASC addenda which are posted to the CMS Web site at *http://www.cms.gov/HospitalOutpatientPPS/HORD.*

In addition, the CY 2012 Statewide Average CCRs displayed in Table 11 (76 FR 74195 through 74198) and in the Annual Policy Files section on the CMS Web site at *http://www.cms.gov/HospitalOutpatientPPS/have* also been revised for CY 2012 and CY 2011 Cost-to-Charge Ratio (CCR) values. The tables incorrectly contain CY 2012 proposed rule CCR values as the Final CY 2012 Default CCR for Table 11 and as the Previous Default CCRs in the Annual Policy file. 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.

We are correcting an amendatory instruction in regulations text § 416.171. In the amendatory instructions for § 416.171, we inadvertently revised the entire paragraph (b). Paragraph (b) contains 3 subparagraphs, (b)(1) through (3), respectively. We intended only to revise paragraph (b) introductory text, while making no additional changes to the subparagraphs. Therefore, we are correcting this error.

B. Hospital Value-Based Purchasing Corrections

Section 1886(o)(1)(C)(iii) of the Act requires the Secretary to conduct an independent analysis of appropriate minimum numbers of cases and measures for scoring under the Hospital Inpatient Value-Based Purchasing Program. In the CY 2012 OPPS/ASC final rule with comment period, we inappropriately referred to analyses performed by Brandeis University and Mathematica Policy Research together despite their slightly differing subjects and implications for CMS policies. This document corrects the erroneous references.

III. Waiver of Proposed Rulemaking and the 30-Day Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). We also ordinarily provide a 30-day delay in the effective date of the provisions of a notice in accordance with section 553(d) of the APA (5 U.S.C. 553(d)). However, we can waive both the notice and comment procedure and the 30-day delay in effective date if the Secretary finds, for good cause, that it is impracticable, unnecessary, or contrary to the public interest to follow the notice and comment procedure or to comply with the 30-day delay in the effective date, and incorporates a statement of the finding and the reasons therefore in the notice.

The policies and payment methodologies finalized in the CY 2012 OPPS/ASC final rule with comment period have previously been subjected to notice and comment procedures. This correction notice merely provides technical corrections to the CY 2012 OPPS/ASC final rule with comment period that was promulgated through notice and comment rulemaking, and does not make substantive changes to the policies or payment methodologies that were finalized in the final rule with comment period. For example, to conform the document to the final policies of the CY 2012 OPPS/ASC final, this notice makes changes to revise inaccurate tabular information. Therefore, we find it unnecessary to undertake further notice and comment procedures with respect to this correction notice. In addition, we believe it is important for the public to have the correct information as soon as possible and find no reason to delay the dissemination of it. For the reasons stated above, we find that both notice and comment and the 30-day delay in effective date for this correction notice are unnecessary. Therefore, we find there is good cause to waive notice and comment procedures and the 30-day delay in effective date for this correction notice.

IV. Correction of Errors

■ In FR Doc. 2011–28612 of November 30, 2011 (76 FR 74122), make the following corrections:

A. Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Preamble Corrections

■ 1. On page 74189, in the first column, in the second full paragraph, in line 14, replace 1.3588 with 1.3585.

■ 2. On pages 74195 through 74198, Table 11—CY2012 Statewide Average CCRs, is corrected to read as follows:

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Revised Table 11 CY 2012 STATEWIDE AVERAGE CCRs

State	Urban/Rural	Final CY 2012 Default CCR	Previous Default CCR (CY 2011 OPPS Final Rule)
ALASKA	RURAL	0.487	0.479
ALASKA	URBAN	0.305	0.315
ALABAMA	RURAL	0.210	0.212
ALABAMA	URBAN	0.194	0.193
ARKANSAS	RURAL	0.221	0.223
ARKANSAS	URBAN	0.245	0.282
ARIZONA	RURAL	0.237	0.231
ARIZONA	URBAN	0.190	0.202
CALIFORNIA	RURAL	0.193	0.195
CALIFORNIA	URBAN	0.201	0.205
COLORADO	RURAL	0.342	0.350
COLORADO	URBAN	0.226	0.233
CONNECTICUT	RURAL	0.365	0.356
CONNECTICUT	URBAN	0.288	0.291
DISTRICT OF COLUMBIA	URBAN	0.302	0.313
DELAWARE	RURAL	0.280	0.279
DELAWARE	URBAN	0.347	0.362
FLORIDA	RURAL	0.182	0.185
FLORIDA	URBAN	0.164	0.172
GEORGIA	RURAL	0.238	0.246
GEORGIA	URBAN	0.214	0.220
HAWAII	RURAL	0.321	0.356
HAWAII	URBAN	0.306	0.308
IOWA	RURAL	0.296	0.252
IOWA	URBAN	0.269	0.288
IDAHO	RURAL	0.417	0.419
IDAHO	URBAN	0.353	0.384
ILLINOIS	RURAL	0.238	0.251
ILLINOIS	URBAN	0.230	0.239
INDIANA	RURAL	0.292	0.302
INDIANA	URBAN	0.262	0.270
KANSAS	RURAL	0.279	0.286
KANSAS	URBAN	0.208	0.215
KENTUCKY	RURAL	0.217	0.220
KENTUCKY	URBAN	0.239	0.244
LOUISIANA	RURAL	0.247	0.256

State	Urban/Rural	Final CY 2012 Default CCR	Previous Default CCR (CY 2011 OPPS Final Rule)
LOUISIANA	URBAN	0.224	0.235
MARYLAND	RURAL	0.276	0.284
MARYLAND	URBAN	0.246	0.256
MASSACHUSETTS	RURAL	0.427	N/A
MASSACHUSETTS	URBAN	0.322	0.314
MAINE	RURAL	0.438	0.460
MAINE	URBAN	0.453	0.450
MICHIGAN	RURAL	0.305	0.312
MICHIGAN	URBAN	0.305	0.320
MINNESOTA	RURAL	0.482	0.483
MINNESOTA	URBAN	0.320	0.311
MISSOURI	RURAL	0.243	0.258
MISSOURI	URBAN	0.260	0.264
MISSISSIPPI	RURAL	0.224	0.229
MISSISSIPPI	URBAN	0.189	0.182
MONTANA	RURAL	0.434	0.444
MONTANA	URBAN	0.386	0.399
NORTH CAROLINA	RURAL	0.251	0.254
NORTH CAROLINA	URBAN	0.257	0.264
NORTH DAKOTA	RURAL	0.322	0.351
NORTH DAKOTA	URBAN	0.421	0.360
NEBRASKA	RURAL	0.318	0.328
NEBRASKA	URBAN	0.252	0.259
NEW HAMPSHIRE	RURAL	0.323	0.323
NEW HAMPSHIRE	URBAN	0.291	0.290
NEW JERSEY	URBAN	0.212	0.221
NEW MEXICO	RURAL	0.264	0.277
NEW MEXICO	URBAN	0.288	0.307
NEVADA	RURAL	0.233	0.269
NEVADA	URBAN	0.167	0.178
NEW YORK	RURAL	0.419	0.415
NEW YORK	URBAN	0.356	0.375
OHIO	RURAL	0.320	0.327
OHIO	URBAN	0.234	0.241
OKLAHOMA	RURAL	0.239	0.260
OKLAHOMA	URBAN	0.217	0.208
OREGON	RURAL	0.311	0.306
OREGON	URBAN	0.328	0.340

State	Urban/Rural	Final CY 2012 Default CCR	Previous Default CCR (CY 2011 OPPS Final Rule)
PENNSYLVANIA	RURAL	0.270	0.275
PENNSYLVANIA	URBAN	0.199	0.210
PUERTO RICO	URBAN	0.492	0.505
RHODE ISLAND	URBAN	0.270	0.284
SOUTH CAROLINA	RURAL	0.211	0.222
SOUTH CAROLINA	URBAN	0.214	0.227
SOUTH DAKOTA	RURAL	0.307	0.316
SOUTH DAKOTA	URBAN	0.252	0.251
TENNESSEE	RURAL	0.211	0.221
TENNESSEE	URBAN	0.199	0.204
TEXAS	RURAL	0.236	0.245
TEXAS	URBAN	0.196	0.216
UTAH	RURAL	0.379	0.386
UTAH	URBAN	0.359	0.362
VIRGINIA	RURAL	0.226	0.241
VIRGINIA	URBAN	0.239	0.263
VERMONT	RURAL	0.407	0.411
VERMONT	URBAN	0.384	0.365
WASHINGTON	RURAL	0.368	0.367
WASHINGTON	URBAN	0.298	0.327
WISCONSIN	RURAL	0.351	0.412
WISCONSIN	URBAN	0.311	0.334
WEST VIRGINIA	RURAL	0.280	0.291
WEST VIRGINIA	URBAN	0.337	0.337
WYOMING	RURAL	0.386	0.393
WYOMING	URBAN	0.302	0.296

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■ 3. On page 74208, in the third column, in the first response to comment, in line 17, replace $1,900 with $2,025.

■ 4. On page 74209, in the first column, under the heading ''3. Final Outlier Calculation,''—

■ A. In the first full paragraph, in line 31, replace $1,900 with $2,025.

■ B. In the second paragraph, replace $1,900 with $2,025.

■ 5. On page 74210, in the third column, in the third paragraph—

■ A. In line 16, replace $307.74 with $309.46.

■ B. In line 19, replace $301.59 with $303.27.

■ 6. On page 74210, in the third column, in the fourth paragraph—

■ A. In line 5, replace $242.66 with $244.02 and $307.74 with $309.46.

■ B. In line 8, replace $237.81 with $239.14 and $301.59 with $303.27.

■ C. In lines 10 and 11, replace $123.10 with $123.78 and replace $307.74 with $309.46.

■ D. In lines 13 and 14, replace $120.63 with $121.31 and replace $301.59 with $303.27.

■ E. In line 16, replace $365.76 with $367.80.

■ F. In line 17, replace $242.66 with $244.02 and $123.10 with $123.78.

■ G. In line 19, replace $358.44 with $360.44 and $237.81 with $239.14, and replace $120.63 with $121.31.

■ 7. On page 74211, in the second column, under ''Step 1. Calculate the beneficiary* * *.''—

■ A. In line 5, replace $61.55 with $61.90.

■ B. In line 7, replace $307.74 with $309.46.

■ 8. On page 74227, in Table 19—Final APC Exceptions to the 2 Times Rule for CY 2012, the APC codes are revised by replacing APC code 0262 with APC code 0105, and APC 0341 with APC code 0263, and APC 0660 with APC code 0655. The APC codes are listed in numerical order.

■ 9. On page 74448, in the third column—

■ A. In the first full paragraph, in line 6, replace 0.9466 with 0.9477.

■ B. In the second paragraph, in line 6, replace 0.9466 with 0.9477.

■ 10. On pages 74562 through 74565, Table 59—Estimated Impact of the Final CY 2012 Changes for the Hospital

Outpatient Prospective Payment System, is corrected to read as follows:

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TABLE 59—ESTIMATED IMPACT OF THE FINAL CY 2012 CHANGES FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENTS SYSTEM

	Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	New Cancer Hospital Adjustment (4)	Comb (cols 2,3, & 4) with Market Basket Update (5)	Column 5 with Frontier Wage Index Adjustment (6)	All Changes (7)
ALL FACILITIES *	4,160	0.0	0.0	0.0	1.9	2.0	1.8
ALL HOSPITALS	3,894	0.2	0.0	-0.2	1.9	2.0	1.8
(excludes hospitals permanently held harmless and CMHCs)							
URBAN HOSPITALS	2,945	0.2	0.0	-0.2	2.0	2.0	1.9
LARGE URBAN (GT 1 MILL.)	1,607	0.2	0.1	-0.2	2.0	2.0	1.9
OTHER URBAN (LE 1 MILL.)	1,338	0.2	0.0	-0.2	1.9	2.1	1.9
RURAL HOSPITALS	949	0.1	-0.3	-0.2	1.5	1.7	1.5
SOLE COMMUNITY	384	0.0	-0.2	-0.2	1.5	2.0	1.4
OTHER RURAL	565	0.2	-0.4	-0.2	1.5	1.5	1.5
BEDS (URBAN)							
0 - 99 BEDS	1,028	-0.5	0.1	-0.2	1.2	1.3	1.2
100-199 BEDS	841	0.3	0.2	-0.2	2.1	2.2	2.0
200-299 BEDS	454	0.4	0.1	-0.2	2.3	2.4	2.2
300-499 BEDS	419	0.3	-0.2	-0.2	1.8	1.9	1.8
500 + BEDS	203	0.1	0.1	-0.2	1.9	1.9	1.9
BEDS (RURAL)							
0 - 49 BEDS	349	-0.1	-0.1	-0.2	1.5	1.8	1.5
50- 100 BEDS	355	0.0	-0.3	-0.2	1.4	1.7	1.4
101- 149 BEDS	140	0.2	-0.2	-0.2	1.7	1.9	1.7
150- 199 BEDS	57	0.0	-0.5	-0.2	1.2	1.8	1.2
200 + BEDS	48	0.1	-0.3	-0.2	1.5	1.5	1.4

		Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	New Cancer Hospital Adjustment (4)	Comb (cols 2,3, & 4) with Market Basket Update (5)	Column 5 with Frontier Wage Index Adjustment (6)	All Changes (7)
VOLUME (URBAN)								
	LT 5,000 Lines	597	-5.4	0.4	-0.2	-3.4	-3.2	-3.1
	5,000 - 10,999 Lines	146	-2.1	0.1	-0.2	-0.4	-0.1	-0.4
	11,000 - 20,999 Lines	235	-0.7	-0.1	-0.2	0.9	0.9	0.9
	21,000 - 42,999 Lines	477	0.3	-0.1	-0.2	1.9	1.9	1.8
	42,999 - 89,999 Lines	713	0.5	0.2	-0.2	2.3	2.4	2.2
	GT 89,999 Lines	777	0.2	0.0	-0.2	1.9	2.0	1.9
VOLUME (RURAL)								
	LT 5,000 Lines	67	-0.8	-0.6	-0.2	0.3	2.8	0.4
	5,000 - 10,999 Lines	71	0.7	0.3	-0.2	2.7	2.8	2.5
	11,000 - 20,999 Lines	174	0.3	-0.1	-0.2	1.8	2.1	1.7
	21,000 - 42,999 Lines	282	0.3	-0.2	-0.2	1.8	2.0	1.8
	GT 42,999 Lines	355	0.0	-0.3	-0.2	1.4	1.6	1.4
REGION (URBAN)								
	NEW ENGLAND	150	-0.2	4.2	-0.2	5.7	5.7	5.4
	MIDDLE ATLANTIC	355	0.1	0.0	-0.2	1.8	1.8	1.5
	SOUTH ATLANTIC	449	0.3	-0.5	-0.2	1.5	1.5	1.6
	EAST NORTH CENT.	472	0.3	-0.7	-0.2	1.3	1.3	1.1
	EAST SOUTH CENT.	183	0.6	-0.8	-0.2	1.5	1.5	1.5
	WEST NORTH CENT.	190	0.1	-0.1	-0.2	1.7	2.5	1.8
	WEST SOUTH CENT.	498	0.3	0.1	-0.2	2.1	2.1	2.1
	MOUNTAIN	208	0.1	-0.2	-0.2	1.6	2.0	1.6
	PACIFIC	394	0.1	0.2	-0.2	2.0	2.0	1.9
	PUERTO RICO	46	0.3	0.4	-0.2	2.3	2.3	2.3
REGION (RURAL)								
	NEW ENGLAND	25	-0.9	-0.3	-0.2	0.4	0.4	0.5
	MIDDLE ATLANTIC	67	-0.2	0.1	-0.2	1.6	1.6	1.6
	SOUTH ATLANTIC	162	0.2	-0.2	-0.2	1.7	1.7	1.7
	EAST NORTH CENT.	128	0.0	-0.8	-0.2	0.8	0.8	0.7
	EAST SOUTH CENT.	170	0.6	-0.6	-0.2	1.7	1.7	1.7

		Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	New Cancer Hospital Adjustment (4)	Comb (cols 2,3, & 4) with Market Basket Update (5)	Column 5 with Frontier Wage Index Adjustment (6)	All Changes (7)
	WEST NORTH CENT.	101	-0.3	0.1	-0.2	1.5	2.7	1.6
	WEST SOUTH CENT.	200	0.5	-0.1	-0.2	2.1	2.1	2.0
	MOUNTAIN	67	0.0	-0.7	-0.2	1.0	2.8	0.9
	PACIFIC	29	0.0	1.0	-0.2	2.7	2.7	2.8
TEACHING STATUS								
	NON-TEACHING	2,895	0.3	-0.1	-0.2	1.9	2.0	1.9
	MINOR	708	0.3	-0.1	-0.2	1.9	2.1	1.8
	MAJOR	291	-0.2	0.3	-0.2	1.9	1.9	1.8
DSH PATIENT PERCENT								
	0	11	-1.7	-0.2	-0.2	-0.2	-0.2	0.3
	GT 0 - 0.10	353	0.0	0.2	-0.2	1.9	2.0	1.9
	0.10 - 0.16	357	0.3	-0.3	-0.2	1.7	1.7	1.5
	0.16 - 0.23	734	0.3	-0.1	-0.2	1.9	2.1	1.8
	0.23 - 0.35	1,040	0.3	0.0	-0.2	2.0	2.1	1.9
	GE 0.35	785	0.1	0.1	-0.2	1.9	1.9	1.9
	DSH NOT AVAILABLE **	614	-6.1	0.6	-0.2	-3.9	-3.9	-3.8
URBAN TEACHING/DSH								
	TEACHING & DSH	903	0.2	0.1	-0.2	1.9	2.0	1.8
	NO TEACHING/DSH	1,456	0.4	0.0	-0.2	2.1	2.1	2.0
	NO TEACHING/NO DSH	10	-1.7	-0.2	-0.2	-0.2	-0.2	0.3
	DSH NOT AVAILABLE**	576	-6.4	0.7	-0.2	-4.1	-4.1	-4.0
TYPE OF OWNERSHIP								
	VOLUNTARY	2,061	0.2	0.1	-0.2	2.0	2.1	1.9
	PROPRIETARY	1,272	0.1	-0.1	-0.2	1.7	1.7	1.6
	GOVERNMENT	561	0.1	-0.3	-0.2	1.5	1.5	1.5
CMHCs		204	-32.5	-0.3	-0.2	-30.9	-30.9	-30.8
Cancer Hospitals		11	0.5	0.3	11.6	14.3	14.3	13.2

		Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	New Cancer Hospital Adjustment (4)	Comb (cols 2,3, & 4) with Market Basket Update (5)	Column 5 with Frontier Wage Index Adjustment (6)	All Changes (7)
Column (1) shows total hospitals and/or CMHCs.								
Column (2) shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the final recalibration of APC weights based on CY 2010 hospital claims data.								
Column (3) shows the budget neutral impact of updating the wage index by applying the FY 2012 hospital inpatient wage index.								
Column (4) shows the budget neutral impact of the cancer hospital payment adjustment which is estimated to result in an aggregate increase in OPPS payments to cancer hospitals of $71 million when TOPs are included.								
Column (5) shows the impact of all budget neutrality adjustments and the addition of the 1.9 percent OPD fee schedule increase factor (3.0 percent reduced by 1.0 percentage point for the productivity adjustment and further reduced by 0.1 percentage point in order to satisfy statutory requirements set forth in the Affordable Care Act).								
Column (6) shows the non-budget neutral impact of applying the frontier State wage adjustment, after application of the CY 2012 final OPD fee schedule increase factor.								
Column (7) shows the additional adjustments to the conversion factor resulting from a change in the pass-through estimate and adds final outlier payments. This column also shows the expiration of section 508 wages on September 30, 2011 and the application of the frontier State wage adjustment for CY 2012.								
*These 4,160 providers include children and cancer hospitals, which are held harmless to pre-BBA amounts, 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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■ 11. On page 74570 in the third column, in the first full paragraph, in line 9, replace 0.9466 with 0.9477.

B. Hospital Value-Based Purchasing Preamble Corrections

■ 1. On page 74532, second column, under heading ''b. Minimum Number of Cases for Mortality Measures, AHRQ Composite Measures, and HAC Measures,'' first paragraph, lines 1 and 2, replace ''analyses'' with ''analysis'' and remove the words ''and Mathematica''.

■ 2. In line 9, the words ''these analyses'' are corrected to read ''this analysis''.

■ 3. On page 74534, in the first column, under the first response, in line 20, the words ''the analyses'' are corrected to read ''the analysis''.

■ 4. In line 21, the words ''and Mathematica'' are removed.

C. Regulations Text Corrections

§ 416.171 [Corrected]

■ 1. On page 74582, in the second column, in § 416.171, ''Determination of payment rates for ASC services,'' in amendment 7, the instruction ''a. Revising paragraph (b)'' is corrected to read ''a. Revising paragraph (b) introductory text.''

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

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

Dated: December 28, 2011.

Jennifer Cannistra,

Executive Secretary to the Department.

[FR Doc. 2011–33751 Filed 12–30–11; 4:15 pm]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 414, 415, and 495

[CMS–1524–CN and CMS–1436–CN]

RIN 0938–AQ25 and 0938–AQ00

Medicare Program; Payment Policies Under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and Other Revisions to Part B for CY 2012; Corrections

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

ACTION: Correction of final rule with comment period.

SUMMARY: This document corrects technical errors and typographical errors in the final rule with comment period entitled ''Medicare Program; Payment Policies under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and Other Revisions to Part B for CY 2012'' which appeared in the November 28, 2011 **Federal Register**.

DATES: This correcting document is effective January 1, 2012.

FOR FURTHER INFORMATION CONTACT:

Ryan Howe, (410) 786–3355, or Chava Sheffield, (410) 786–2298, for issues related to the physician fee schedule practice expense methodology and direct expense inputs.

Sara Vitolo, (410) 786–5714, for issues related to work RVUs.

Christine Estella, (410) 786–0485, for issues related to the Physician Quality Reporting System, incentives for Electronic Prescribing (eRx) and Physician Compare.

Jamie Hermansen, or (410) 786–2064, or Stephanie Frilling, (410) 786–4507, for issues related to Annual Wellness Visit.

Rebecca Cole, (410) 786–4497, for issues related to physician payment not previously identified.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2011–28597 of November 28, 2011 (76 FR 73026), the final rule with comment period entitled ''Medicare Program; Payment Policies under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and Other Revisions to Part B for CY 2012'' (hereinafter referred to as the CY 2012 PFS final rule with comment period) there were a number of technical errors that are identified and corrected in the Correction of Errors section. Accordingly, the corrections are effective January 1, 2012.

We note that this correction notice corrects the CY 2012 PFS final rule with comment period which reflects laws in effect as of November 1, 2011. Any statutory changes to PFS payment after November 1, 2011 were not reflected in the CY 2012 PFS final rule with comment period and are therefore not reflected in this correction notice. Payment files reflecting current law as of January 1, 2012 were made available through usual CMS notices and data files.

II. Summary of Errors and Corrections to the Addenda Posted on the CMS Web Site

A. Errors in the Preamble

1. Errors in Work Relative Value Units (RVUs) and Time Information

On pages 73028 and 73208, a discussion of CPT codes 96110 (Developmental screening, with interpretation and report, per standardized instrument form) and G0451 (Development testing, with interpretation and report, per standardized instrument form) was omitted from the final rule due to an inadvertent error. We note that we had cited a discussion regarding these two codes several times throughout the preamble. We are correcting this error by including our intended discussion through this correcting document.

On page 73141, we are correcting our response to comments to accurately reflect our policy regarding CPT codes 53445 (Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff) and 54410 (Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session). Due to an inadvertent error, the discussion of these codes did not reflect our discussion of revisions to the times for these codes for CY 2012. We include our discussion of time policies for these codes on an interim final basis for CY 2012.

On page 73166, we are correcting an inadvertent error in Table 15: CY 2012 Work RVUs for Services Reviewed in the CY 2011 PFS Final Rule with Comment Period, the Fourth-Five Year Review, and the CY 2012 PFS Proposed Rule. This table incorrectly identified that no time change had occurred for CPT code 53445.

On pages 73172 and 73178, we are correcting Table 16: CY 2011 and AMA RUC-Recommended Physician Time and Work Values for CY 2012 to accurately reflect time values for CPT codes 23415 (Coracoacromial ligament release, with or without acromioplasty), as well as revisions to the times for 53445 and 54410 already noted. The time values for CPT code 23415 that were listed in the CY 2012 PFS final rule time file were correct, but were inadvertently left out of Table 16. The time values for CPT codes 53345 and 54410 that were listed in the CY 2012 PFS final rule time file were not correct; the time file has been corrected to reflect correct times for CPT codes 53445 and 54410, previously discussed. We note that the time file that we used to calculate RVUs for the CY 2012 PFS final rule with comment period did not reflect the correct finalized published times in Table 16 on pages 73170 through 73181 for a limited number of codes. Specifically, we also have corrected the time values in the time file for CPT codes 28725 (Arthrodesis; subtalar), 28730 (Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse), 62223 (Creation of shunt; ventriculo-peritoneal, -pleural, other terminus), 65285 (Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue), 73080 (Radiologic examination, elbow; complete, minimum of 3 views), 73610 (Radiologic examination, ankle; complete, minimum of 3 views), and 73630 (Radiologic examination, foot; complete, minimum of 3 views) to reflect the correct time values in Table 16.